Manatee Diagnostic Center

Name: _____ _____ Social Security Number: _____

Date of Birth: _____ Age: _____ Employer: _____

Local Mailing Address: _____

Address Line 2: _____

City: _____ State: _____ Zipcode: _____

Phone Numbers

Mobile: _____ Home: _____ Work: _____

E-Mail: _____

Please list an EMERGENCY CONTACT:

Name and Phone: _____

This person may be informed about your medical information including diagnosis, payments and procedures.

WE MUST HAVE A COPY OF ALL YOUR CURRENT INSURANCE CARDS

DO YOU HAVE MEDICARE? ☐ YES ☐ NO If "yes", is it ☐ Primary ☐ Secondary

Name of Carrier: Group Number: Policy Number:

IF INSURANCE POLICY HOLDER IS OTHER THAN PATIENT, PLEASE GIVE THE FOLLOWING:

Name of Policy Holder: _____ Relationship to Patient: _____

Policy Holder's Date of Birth: _____ Employer: _____

Home Phone: _____ SSN: _____

Address (if different than Patient) _____

Street Address including PO Box if appropriate

_____

CITY STATE ZIP CODE

PLEASE TURN PAGE OVER TO COMPLETE THIS FORM--THANK YOU!!

AUTHORIZATION & CONSENT

- **MEDICARE PART B SIGNATURE AUTHORIZATION:** I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carriers, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits, either to myself or to the party who accepts signature.

  INSURANCE INFORMATION AUTHORIZATION: I authorize the release of any medical information necessary to process insurance claims. I further authorize payment of the medical benefits to Manatee Diagnostic Center in the event they file for the insurance. I permit a copy of this authorization to be used in place of the original.

  I understand that I am responsible for the payment of this bill. I also understand that Manatee Diagnostic Center will file my Medicare/Insurance as a courtesy to me. If my claim is denied, I will be responsible for payment of the patient portion of this bill. I further understand that in the event any balance of my bill remains unpaid 90 days after the date of service, Manatee Diagnostic Center has the right to charge interest at the rate of 15% per annum on any unpaid portion of my bill until paid in full. Furthermore, I understand that if Manatee Diagnostic Center must undertake collection efforts for my unpaid bill, I will also be responsible for the payment of any and all collection costs, including attorney fees, incurred by Manatee Diagnostic Center, which costs will be added to the unpaid balance of my bill.

- I have been provided with a copy of the Patient Privacy Policy for Manatee Diagnostic Center.

- I have been given information about my rights and responsibilities while receiving care and services at Manatee Diagnostic Center.

- **Manatee Diagnostic Center is committed to provide quality patient care. While we respect a patient's right to have an advance directive or living will, it is our policy that resuscitation attempts will be made in the event of a life-threatening emergency.**

X _____ Date _____

PATIENT OR PARENT/LEGAL GUARDIAN SIGNATURE (REQURIED IF PATIENT IS UNER 18 YEARS OF AGE)

WITNESS _____

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

This allows Manatee Diagnostic Center to send your results to your doctor.

I AUTHORIZE DISCLOSURE OF THE HEALTH INFORMATION SPECIFEID BELOW:

Patient's Name:	Maiden / Previous Name: _____
Patient's Birth Date:	Medical Record Number:

I authorize the following provider(s) to disclose information to Manatee Diagnostic Center:

_____

_____

_____

I authorize Manatee Diagnostic Center to disclose information to the following provider(s):

_____

_____

_____

FOR THE PURPOSE OF: ☐ Treatment ☐ Billing ☐ Other _____

THE FOLLOWING INFORMATION IS TO BE DISCLOSED / RELEASED:

☐ Radiology Reports / Images ☐ Lab Results ☐ Other _____

I understand that this will not included information relating to the below items. This information cannot be disclosed verbally.

- Acquired immunodeficiency syntrom (AIDS) or human immunodeficiency Virus (HIV) infection
- Mental Health
- Treatment for alcohol and/or drug abuse
- Sexually Transmitted Disease

POSSIBILITY OF REDISCLOSURE: I understand that any information released may be subject to re-disclosure and no longer protected by state and federal regulations.

EXPIRATION AND REVOCATION: I understand that this authorization is valid for 5 years from the date I sign it, or until _____ (date or event). I have the right to revoke this authorization in writing at any time. The revokation will take effect on the day it is received except to the extent it has already been acted upon or if the authorization was obtained as a condition of obtaining insurance coverage.

CONDITIONS OF TREATMENT: I understand that Manatee Diagnostic Center cannot condition treatment upon my signing of this authorization.

_____ _____

Signature of Patient or Legally Authorized Representative* Date

*If other than patient signing, state relationship: _____

_____ _____

Signature of Witness Date