American Imaging of Southwest Florida
23081 Harborview Rd, Port Charlotte, FL 33980
941-235-8762 (Office) 941-237-5691(Fax)

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Telephone Numbers: (C)_____ (H)_____ (W) _____

I authorize: _____, to release _____to American Imaging.

This authorization for release of information is valid indefinitely from the date of signature unless revoked by written notice to the providing institution. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to consent a claim under my policy. I understand that once the information is disclosed pursuant to this authorization, the recipient may re-disclose it and the authorization will not affect my Ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law.

I grant permission for the employees of American Imaging of Southwest Florida to render care to me and expedite the orders of the physicians and or physician extender. I authorize release of this information to other healthcare providers associated with my care. I permit/refuse _____, to discuss my medical record and/or billing information.

I authorized American imaging of Southwest Florida to furnish information to insurance carriers concerning my care. I Agree to pay an American imaging of Southwest Florida for all services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by my insurance and if I have not secured a proper authorizations and otherwise complied with the terms of my benefit plan, there may be a decrease or no coverage at all for services rendered at American imaging of Southwest Florida. For self-pay patients I also understand that I am responsible for all services rendered to my dependents or myself. Co-pays and self-pay charges are due at the time of service. Outstanding balances referred to a collection agency will be assessed an additional fee equal to the collection fee no greater than 35% of the balance owed.

Patient Signature: X _____ Date: _____

Email authorization

I hereby authorize American Imaging of Southwest Florida to email me at, _____ with current practice updates whenever possible. I understand that American Imaging of Southwest Florida will not share my email address with any other persons or agencies. This authorization will remain in effect until I revoke this authorization in writing.

Patient Signature: X _____ Date: _____

Acknowledgment of Receipt of Notice of Privacy Practices

Your name and signature on this section indicates you received a copy of American Imaging of Southwest Florida's notice of privacy practices on the date indicated if you have any questions regarding the information in your notice of privacy practices, please do not hesitate to contact our privacy officer at 941–235–8762.

Patient Signature: X _____ Date: _____

Assignment of Benefits Form

I, _____, hereby authorize benefits to be assigned to American Imaging of Southwest Florida, for healthcare service provided to me or my dependent by American Imaging of Southwest Florida. I hereby certify that the insurance information that I provided is true and accurate as of the date of service and that I am responsible for keeping updated. I am fully aware that having health insurance does not absolve me of my financial responsibility. I also understand that my insurance company may not pay 100% of the amount of the medical claim. I am responsible for any and all amounts not paid by my insurance company including any portion paid and not applied to in network benefits or any out of network services.

I hereby authorize American Imaging Southwest Florida to submit claims on my behalf, to the insurance company listed on the copy of the current insurance card I have provided American Imaging of Southwest Florida. I fully agree and understand that the submission of a claim does not absolve me of my responsibility to ensure that the claim is paid in full.

I hereby irrevocably designate, authorize and appoint American Imaging of Southwest Florida as my true and lawful attorney-in-fact. This power of attorney is hereby provided for the limited purpose of receiving all payments due under my policy or medical care plan for services rendered to me or my dependents. This power of attorney shall automatically terminate, without formal action being taken, as soon as American Imaging of Southwest Florida has received payment in full and remedies under applicable regulatory guidelines for all medical care services provided to the patient. I hereby confirm and ratify all actions taken by my attorney-in-fact pursuant to the authority granted herein. I hereby authorize my insurer to assign and transfer any applicable ERISA plan benefits and rights to American imaging of Southwest Florida, including the right to receive any applicable plan documents, remedies, pursue appeals, administrative reviews or litigation on my behalf. This authorization includes any other right to do me permissible under state and federal laws. I authorize American Imaging of Southwest Florida to request on my behalf as needed all levels of appeal and or any administrative review do me by the US Department of labor, Department of Health, Department of Insurance pursuant to State and or Federal ERISA claim regulatory guidelines.

I hereby instruct and direct my insurance company to pay American Imaging of Southwest Florida directly. I understand under ERISA that I have the right and authority to direct my payment for services rendered are sent. If my current policy prohibits direct payment to the provider of services, I under my rights per State and Federal ERISA regulations hereby instruct and direct my insurance company to provide SPD documentation stating such non-assignability clause to myself and American Imaging of Southwest Florida. Upon proof of non-assignability documentation, I then instruct that the insurer make out the check to me and mail it directly to American Imaging of Southwest Florida at 23081 Harborview Rd., Port Charlotte Florida, 33980 for the professional or medical expense benefits, and otherwise payable to me under current insurance policy as payment towards the total charge for the professional services rendered. I agree and understand that any funds I receive from my insurance company due for services rendered at American Imaging of Southwest Florida will be immediately signed over and sent directly to American Imaging Southwest Florida. In the event I need to have lab work, American Imaging may use an outside lab which may also file an insurance claim for the outside lab services required for my plan of care. This may or may not be covered under my plan and American imaging Southwest Florida is not responsible for any charges incurred.

This is a direct assignment of my rights and benefits under this plan/policy. This payment will not exceed my indebtedness to the above mentioned assignee, I have agreed to pay, and a current manner, any balance of said professionals service charge over and above this insurance payment. Upon receipt of said check I authorize American Imaging of Southwest Florida to receive any such checks, endorse them for deposit only and to deposit and apply all the proceeds toward payment on my account.

I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I authorize American Imaging Southwest Florida to be my personal representative, which allows American Imaging of Southwest Florida to: 1. Submit any and all appeals when my insurance come Company denies me benefits to which I am entitled. 2. Submit all any and all request for benefit information from my insurance company, and 3. Initiate formal complaints to the State or Federal agency that has jurisdiction over by benefits. I fully understand and agree that I am responsible for payment for all of the medical debt if my insurance company has refused to pay 100% of my benefits based on billed charges, within 90 days of any and all appeals or request for information. Should the account be referred to an attorney or outside agency for collection, I understand in the undersigned shall pay responsible attorney's fees and collection expenses. All the liquid accounts bear interest at the legal rate. I also agree that any fines Leavitt against my insurance company will be paid to American Imaging of Southwest Florida for acting as my personal representative.

I authorize American Imaging of Southwest Florida and its associates provide medical care reasonable by today standards. The photo copy this agreement shall be considered as effective as an original signature.

_____ _____

Signature of Patient or Guarantor Date

_____ _____ _____ _____

Signature of Policy Holder Date Witness Date