



OMI OF GADSDEN PETCT, LLC

Medicare & MediGap Authorization (crossover claims) & Assignment of Benefits/Authorization to Release Information

I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION & HEALTHCARE FINANCING ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I PERMIT A COPY OF THE 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 ASSIGNMENT. I UNDERSTAND IT IS MADATORY TO NOTIFY THE HEALTH CARE PROVIDER OF ANY OTHER PARTY WHO MAY BE RESPONSIBLE FOR PAYING FOR MY TREATMENT. (SECTION 1128B OF THE SOCIAL SECURITY ACT AND 31 U.S.C 3801-3812 PROVIDERS PENALTIES FOR WITHHOLDING THIS IMFORMATION.) REGULATIONS PERTAINING TO MEDICARE ASSIGNMENT OF BENEFITS ALSO APPLY.

I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO OMI OF GADSDEN PETCT, LLC ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDIGAP CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF ORIGINAL AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT.

I HEREBY ASSIGN ALL MEDICAL BENEFITS TO INCLUDE MAJOR MEDICAL BENEFITS TO WHICH I AM ENTITLED, INCLUDING MEDICARE, PRIVATE INSURANCE, BLUE CROSS BLUE SHIELD, MEDICAID, AND ANY OTHER HEALTH PLAN TO OMI OF GADSDEN PETCT, LLC. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCLUDING NON-COVERED CHARGES.

I HEREBY AUTHORIZE THE RELEASE OF ALL INFORMATION NECESSARY TO SECURE PAYMENT OF CLAIMS AND TO COMPLETE ANY NECESSARY FORMS PRESENTED TO OMI OF GADSDEN PETCT. I HEREBY AUTHORIZE OMI OF GADSDEN PETCT TO RELEASE & FAX INFORMATION & ALSO REQUEST & RECEIVE ANY INFORMATION REQUIRED IN THE COURSE OF MY TREATMENT.

THIS ORDER WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING.

SIGNED: _____ DATE: _____

PARENT OR LEGAL GUARDIAN _____ DATE: _____



PATIENT HISTORY SHEET

NAME _____

DATE _____

PRESENT WEIGHT _____

PLEASE LIST ANY PHYSICIANS (OTHER THAN YOUR REFERRING PHYSICIAN) THAT SHOULD RECEIVE A COPY OF YOUR REPORT

_____, _____, _____, _____

ARE YOU DIABETIC? YES/NO

IF SO, WHAT MEDICINES DO YOU TAKE TO CONTROL YOUR DIABETES?

_____, _____, _____, _____

PLEASE LIST ALL SURGERIES AND THEIR DATES:

HAVE YOU RECEIVED CHEMOTHERAPY? YES/NO

IF SO, WHEN WAS YOUR LAST TREATMENT? _____

HAVE RECEIVED RADIATION THERAPY? YES/NO

IF SO, WHEN WAS YOUR LAST TREATMENT? _____

WHAT PART OF YOUR BODY WAS TREATED? _____

HAVE RECEIVED IMMUNOTHERAPY? YES/NO

IF SO, WHEN WAS YOUR LAST TREATMENT? _____

PLEASE LIST ALL ALLERGIES:



OMI OF GADSDEN PETCT, LLC

PATIENT DEMOGRAPHIC & INSURANCE INFORMATION

DATE _____

NAME _____
FIRST MIDDLE LAST

BIRTH DATE _____ GENDER F M

SOCIAL SECURITY NUMBER: _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE(____) _____ WORK PHONE _____ CELL _____

EMAIL ADDRESS _____

PATIENTS RELATIONSHIP TO INSURED?

____ SELF ____ CHILD ____ SPOUSE ____ GUARDIAN ____ OTHER _____

ADDITIONAL PATIENT INFORMATION

MARITAL STATUS __ SINGLE __ MARRIED __ DIVORCED __ WIDOWED

MAY WE CONTACT YOU AT YOUR WORK? __ YES __ NO

MAY WE LEAVE YOU A VOICEMAIL OR TEXT? __ YES __ NO

INSURED INFORMATION

NAME: _____ HOME PHONE: _____

DATE OF BIRTH: _____ CELL _____

STREET ADDRESS
(IF DIFFERENT FROM (PATIENT) _____

CITY _____ STATE _____ ZIP _____

EMERGENCY CONTACT INFORMATION

NAME/S _____ RELATIONSHIP: _____

PHONE _____



OMI OF GADSDEN PETCT, LLC

I ACKNOWLEDGE THAT I HAVE BEEN PROVIDED ACCESS TO NOTICE OF PRIVACY PRACTICES OF OMI OF GADSDEN PETCT, LLC

SIGNATURE OF PATIENT

NAME OF PATIENT OR REPRESENTATIVE

DATE

RELATIONSHIP TO PATIENT

Consent of the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare this practice (OMI of Gadsden PETCT, LLC) originates and maintains health records describing my health history, symptoms, examination, and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- ❖ A basis for planning my care & treatment
- ❖ A means of communication among the many healthcare professionals who may contribute to my care
- ❖ A source of information for applying my diagnosis and treatment information to my bill
- ❖ A means by which a third-party payor can verify that services billed were actually provided
- ❖ A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided access to a **Notice of Information Practices** that provides a more complete description of information uses and disclosure. I understand that I have the right to review the Notice prior to signing this consent. I understand that the organization (OMI of Gadsden PETCT, LLC) reserves the right to change its notices and practices. I understand that I have the right to object to the use of my healthcare information for directory purposes. I understand that I have the right to request restrictions as to how my healthcare information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization (OMI of Gadsden PETCT, LLC) is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I wish to have following restrictions to the use of my health information:

I fully understand & accept decline the terms of this consent.

Signature: _____ Date: _____

In order to maintain patient CONFIDENTIALITY our staff will not discuss your medical care and or billing questions with anyone other than you. If you wish to authorize us to discuss your medical care and or billing questions with anyone else, please list them below.

Contact
Name _____ Relationship _____ Phone# _____

Contact
Name _____ Relationship _____ Phone# _____

Signature _____

OFFICE FINANCIAL POLICY

**Our office hours are Monday thru Friday from 8:00 am to 5:00 pm.
This Facility sees patients by appointment only. Referral from a Physician is necessary to receive service.**

Our Facility is An Independent Diagnostic Testing Facility (IDTF) and participates with several PPO, Governmental (Medicare/Medicaid) and Commercial insurance plans. We will bill your insurance company for our services. Your co-pay and/or deductible is due when services are rendered.

Our Insurance department will bill your insurance company. After your insurance has submitted payment, a statement will be sent to you for any outstanding balance.

Accounts over 30 days are considered past due. It is our policy if an account is over 90 days past due, we may submit this information to a collection agency.

I hereby authorize this facility to release and fax information and request and receive any information required in the course of my procedure.

Thank you for entrusting us with your PET/CT Scan Service.

I hereby agree to the terms and conditions of the above office financial policy.

Patients Signature: _____ Date: _____

Responsible

Party/Guarantor: _____ Date: _____