POM MRI
& RADIOLOGY CENTERS

954-900-2020

1. PATIENT INFORMATION (fields with a * are required)

First Name:* | Middle Name or Initial: | Last Name:*

Gender:*
○ Female ○ Male

Date of Birth:* | Mobile Phone:* | Home Phone:

Work Phone: | Email:

Preferred contact method:
○ Mobile Phone ○ Home Phone
○ Work Phone ○ Email

Street Address:* | Apt./Unit #:

City:* | State:* | Zip Code:*

2. PREGNANCY STATEMENT

Are you pregnant/nursing or do you suspect that you could be pregnant?* ○ Yes ○ No

If 'YES', date of your last menstrual period?

3. PATIENT'S MEDICAL HISTORY

Briefly describe your symptoms:

List any over-the-counter or prescription medication you are taking (if none, please write NONE):

Have you had surgery in the area of interest? ○ Yes ○ No

If 'YES', what was the date of surgery?

PLEASE REMOVE ALL PERSONAL ITEMS

Remove all items such as Jewelry, Hairpins, Wigs, Metallic Objects, Hearing Aids, Dentures and Credit Cards. Leave all valuables with a responsible person or store all items in a locker that is provided to you for your convenience.

By signing below, I grant consent for the study and I attest that the answers I have provided to the questions on this form are correct to the best of my knowledge. I have read and understand the entire contents of this firm and have had the opportunity to ask questions regarding the information in this form.

Signature | Date

CT QUESTIONNAIRE

4. Your Age: _____ Your Weight: _____

Why has your physician sent you for a CT Scan?

_____

_____

Do you have any allergies?
○ No ○ Yes

If YES to allergies, please list here:

_____

_____

Have you had any previous adverse reaction(s) to Contrast Material?
○ No ○ Yes

If YES to contrast material, please list here:

_____

_____

Have you ever had a severe life-threatening or Anaphylactic Reaction to food, medication, insect or bug bite?
○ No ○ Yes

If YES, please list here:

_____

_____

Have you ever been diagnosed with Diabetes?
○ No ○ Yes

If YES, do you take:
☐ Glucophage
☐ Metformin
☐ Glucovance

Date of your last dose: _____

When is your next dose? _____

Have you ever been diagnosed with Kidney Disfunction?
○ No ○ Yes

If YES, are you on dialysis? ○ No ○ Yes

If YES, when is your next session? _____

Have you ever been diagnosed with cancer or a serious illness?
○ No ○ Yes

If YES, what was the illness?

_____

_____

Chemo Therapy?
○ No ○ Yes

When? _____

Radiation Therapy?
○ No ○ Yes

When? _____

Do you have any of the following?
☐ High Blood Pressure ☐ Lung Disease ☐ Heart Disease ☐ Asthma

_____ _____

Signature Date

PATIENT'S BILL OF RIGHTS

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

- A patient has the right to know who is providing medical services and who is responsible for his or her care.
- A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
- A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
- A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.
- A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.
- A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- A patient is responsible for following the treatment plan recommended by the health care provider.
- A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.
- A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
- A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
- A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.
- Inform his/her provider about any living will, medical power of attorney or other directive that could affect his/her care.
- Be respectful of all the health care providers and staff, as well as other patients.

I acknowledge that I have electronically received and read a copy of the Patient's Bill of Rights and Responsibilities.

Signature _____ Date _____

FINANCIAL RESPONSIBILITY

5. INDENTIFICATION

Patient's Full Name: _____

Legal Representative's Full Name: _____

PAYMENTS: Due each visit. Payment Options : **CASH or MAJOR CREDIT CARD (2.9% merchant fee).**

MEDICARE: We participate and accept assignment with Medicare part B; we will scan your Medicare card for our files. Deductibles that are not met are your responsibility. Patients without secondary insurance are responsible for the 20% co-insurance.

HMO INSURANCES: We will submit charges for HMO insurances; however, co-pay amounts will be collected prior to your appointment. In order to be seen any referrals required by your insurance company must be in our office before or at the time of the exam. Otherwise, you will be responsible for the charges from your visit or your appointment can be rescheduled.

COMMERCIAL INSURANCES: Although we may participate with some third-party payment plans, we perceive your insurance coverage as a contract between the insurance company and you. Payment for exam is expected at the time of service. We will assist you by providing appropriate insurance forms for your reimbursement. If deductibles are not satisfied, we will expect payment in full at the time of service.

SELF PAY: Patients with no insurance coverage are expected to pay in full at the time of service using any of these payment options: **CASH or MAJOR CREDIT CARD (2.9% merchant fee).**

PATIENT BALANCES: Payment is due upon receipt of statement. Balances not paid within 30 days of initial billing are subject to collections. Should your account be turned over to collections, you will be responsible for all costs of collection and/or attorney's fees.

I have read the above office payment policy and as a patient, or legal guardian of a minor or impaired patient, I understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I have read, understand, and agree to the above office payment policy in accordance with the terms and conditions set forth in the policy of this office. I also hereby attest that I have given accurate insurance information to the best of my knowledge for complete and timely payment. **If authorization is not given by my insurance company, I agree to pay the balance in full.**

PRINT NAME: _____

SIGNATURE: _____Date: _____/____/_____

RECEIPT OF NOTICE OF PRIVACY PRACTICES

6. IDENTIFICATION

7. PLEASE DESCRIBE HOW YOU ARE RELATED TO THE PATIENT.

- ○ Patient (myself)
- ○ Mother / Father
- ○ Brother / Sister
- ○ Spouse
- ○ Son / Daughter
- ○ Legal Guardian / Durable Power of Attorney

I acknowledge that I have received a copy of the POM MRI & Radiology Centers Notice of Privacy Practices. I understand that if I want a printed copy of the Notice of Privacy Practices I can print the attached copy or request a copy from the front desk at POM MRI during my visit.

Signature

Date

COVID-19 PRE-SCREEN AND WAIVER

8. IDENTIFICATION

Patient's Full Name

_____

Legal Representative's Full Name (if applicable)

_____

POM MRI & Radiology Centers ("POM") is committed to your well-being, the well-being of our employees and of our community. In an attempt to stop the spread of the COVID-19 coronavirus we follow or exceed sanitation / disinfection guidelines issued by the Center for Disease Control (CDC). These include, but are not limited to:

1. All front desk staff wearing PPE (masks and/or shields).
2. All technologist staff wearing PPE (masks and/or shields) and gloves.
3. Thoroughly wiping down all service rooms and tools with approved hospital-grade or EPA-registered disinfectants.
4. Limiting the number of patients in the waiting room at any given time.
5. All linens, gowns and scrubs provided to patients during exams are single service use.

FOR YOUR VISIT TODAY YOU ACKNOWLEDGE AND AGREE TO THE FOLLOWING: I understand that the CDC has published the following as symptoms of Covid-19: Fever, cough, shortness of breath or difficulty breathing, chills, repeated shaking with chills, sore throat, new loss of taste or smell.

THE FOLLOWING STATEMENTS ARE TRUE FOR ME, ALL MY HOUSEHOLD MEMBERS AND ANY OTHERINDIVIDUALS I COME IN CLOSE PERSONAL CONTACT WITH ON A REGULAR BASIS:

1. We are not currently experiencing any of the above symptoms.
2. We have not been diagnosed with COVID-19 in the past 30 days.
3. We have not knowingly been exposed to anyone with COVID-19 within the past 14 days.
4. We have not traveled outside of the country or to/from any COVID-19'hot spots' within the past 14 days.

I ALSO ACKNOWLEDGE THE FOLLOWING:

1. A person can unintentionally spread COVID-19 to others even if they do not feel sick or have symptoms.
2. Masks are meant to reduce the possibility of spreading the virus when infection is known or unknown, they do not block the virus.
3. I understand and acknowledge that POM cannot completely control the spread of COVID-19 and I have chosen to enter this business and consent to receive close contact service(s) with full knowledge of the risk of contracting COVID-19 when social distancing is not observed.

Because we are all in this together, all employees of POM also acknowledge and agree to these same standards and statements every day.

By signing below, I agree that, to the fullest extent allowed by law, I accept the possible risks and will hold POM MRI & Radiology Centers harmless from any and all claims due to any exposure to or contracting of COVID-19.

_____ _____

Signature Date

POM MRI
& RADIOLOGY CENTERS

MEDICAL RECORDS RELEASE AUTHORIZATION FORM

Cooper City: 11011 Sheridan St., Ste 101, Cooper City FL 33026
Coral Springs: 2800 N. State Rd 7, Suite 103, Margate FL 33063
Ft. Lauderdale: 4331 N. Federal Hwy, Ste 200, Ft Laud, FL 33308
Plantation: 4373 W. Sunrise Boulevard Plantation, Fl 33313

Patient's Full Name _____

Date of Birth_____ SSN (last 4 digits) _____

Home # (_____)_____

Cell #: (_____)_____

Email: _____

If unable to reach me:
[ ] you may leave a detailed message on my phone
[ ] please leave a message asking me to return your call
[ ] please contact me via email (not secure)
[ ] _____

Street Address_____

City_____State_____Zip_____

I hereby voluntarily authorize the disclosure of information from my health record to be released to:

Name _____

Phone Number_____ Fax Number _____

Street Address_____

City_____State_____Zip_____

I would like my records: ☐ Mailed to the address listed above ☐ Faxed to number listed above

Please check all that apply: ☐ Radiology Reports ☐ Radiology Images: ☐ (CD)

Date(s) of Service: _____

EFFECTIVE PERIOD: This authorization form will remain in effect until my death or the day I withdraw my permission. **ADDITIONALLY**: I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above. I understand that there are some circumstances in which this information may be redisclosed to other medical persons and/or medical providers not specifically listed above and such authorization is expressly implied herein.

_____ _____
Patient or legally authorized representative's signature Date

_____
Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative)

You may revoke this authorization in writing at any time by sending written notification to POM MRI & RADIOLOGY CENTERS, 11011 Sheridan St., Suite 101, Cooper City, Florida 33026. Your notice will not apply to actions taken by the requesting person/entity prior to the date your written request to revoke authorization is received.