Today's Date ____/____/____ X-Ray/File # _____

DIAGNOSTIC IMAGING ASSOCIATES, P.A.

____ Omega Imaging
____ Omega MRI
____ Pike Creek
____ Brandywine
____ Omega Medical
____ Omega Nuclear
____ MRI of Wilmington

****

Patient Name _____
last first MI
Date of Birth ____/____/____ Age _____
Sex _____ Marital Status? S M D W

Address _____

Telephone (_____) _____ - _____
Social Security _____ - ____ - _____

PATIENT EMPLOYER INFORMATION:

Employer Name _____

Address _____

Telephone (_____) _____ - _____

EMERGENCY CONTACT INFORMATION:

Name _____
Date of Birth ____/____/____
Address _____

Telephone (_____) _____ - _____

SPOUSE (or PARENT) EMPLOYER INFORMATION:

Employer Name _____
Address _____

Telephone (_____) _____ - _____

PHYSICIAN INFORMATION:
Referring Physician Name _____
Address _____

Telephone (_____) _____ - _____
Primary Care Physician _____
Copy to Another Physician _____

PRIMARY HEALTH INSURANCE INFORMATION:

Company Name _____

Address _____

Telephone (_____) _____ - _____
ID/Policy # _____
Group # _____
Subscriber Name _____
Effective date of coverage ____/____/____

SECONDARY HEALTH INSURANCE INFORMATION:

Company Name _____

Address _____

Telephone (_____) _____ - _____
ID/Policy # _____
Group # _____
Subscriber Name _____
Effective Date of Coverage ____/____/____

AUTO ACCIDENT OR WORK INJURY INFORMATION:
Are you having this study as a result of:
an Auto Accident? Yes No
an injury at Work? Yes No
Date of Accident or Injury ____/____/____

AUTO ACCIDENT/WORKMAN'S COMP INFORMATION:

Company Name _____

Address _____

Claim Adjuster Name _____
Telephone (_____) _____ - _____
Claim/Case # _____

ATTORNEY INFORMATION:
Are you being represented by an attorney? Yes No

Attorney Name _____

Address _____

Telephone (_____) _____ - _____

PATIENT AUTHORIZATION:
I authorize the release of any medical or other information necessary to process this claim. I authorize my insurance company to pay directly to DIAGNOSTIC IMAGING ASSOCIATES. I understand and agree that any unpaid balance not covered by my insurance will be paid by me.

Signature _____
Date ____/____/____

****

PATIENT ACCOUNT NUMBER _____

Diagnostic Imaging Associates
WWW.DIAXRAY.COM

PATIENT CONSENT FOR FINANCIAL RESPONSIBILITY

PATIENT'S NAME: _____ ACCOUNT #: _____

PATIENT'S SOCIAL SECURITY #: _____

We are committed to providing you with the best possible care and are pleased to discuss our services with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your responsibility.

You will be responsible for any allowed amounts your insurance company does not cover, such as deductible and co-insurance. If you do not have insurance, payment in full is expected at the time of the visit. Patients involved in auto accident, workman's compensation or personal injury lawsuits are, as all other patients, responsible for their bills.

If you do not pay for your services and the bill is sent to a collection agency, you will be responsible for any collection costs.

_____ By initialing, I understand and have been provided with a ***Notice of Health Information Practices*** that provides a detailed description of how my health information may be used or disclosed.

As a member of (Insurance Company Name) _____

Member ID #: _____ Group ID #: _____

I authorize the release of any medical or other information needed to process claims for myself or the patient for whom I am a guardian. I further authorize the patient's insurance company to pay the patient's benefits directly to Diagnostic Imaging Associates.

I understand that: (mark the appropriate box)

☑ An authorization number from my insurance company is not a guarantee of payment. Although I have an authorization for services at this time, I agree to be financially liable for any payment incurred for these services.

☐ A referral form/authorization from my Primary Care Physician/Referring Physician may be required for these services. I acknowledge that **I do not have** a referral form/authorization with me at this time, **but I choose to receive these services** without the required referral form/authorization. I understand that without the appropriate referral form/authorization, my **insurance carrier may not make payment** and **I agree to be financially liable** for any payments incurred for these services.

☐ The services I am about to receive are **non-covered services** for which my **insurance carrier may not make payment** and **I agree to be financially liable** for any payments incurred for these services.

☐ The services I am about to receive **may not be covered** services when performed in an office setting. By choosing to receive these services in a provider's office, rather than the appropriate network setting, my **insurance carrier may not make payment** and **I agree to be financially liable** for any payments incurred for these services.

_____ _____

Patient/Guarantor Signature Date

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions or need more information, please contact the practice's Privacy Officer, Robert B. Hess at (302) 993.2330 ext. 213.

If you believe your privacy rights have been violated, you can file a complaint with Diagnostic Imaging Associates' Privacy Officer or the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the OCR. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH OPERATIONS

We will use your health information for treatment. For example: Information obtained by a technician, physician, or other member of your health care team will be recorded in your record and used to determine the most appropriate course of treatment. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions taken and observations, helping the physician to know how you are responding to treatment. We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you.

We will use your health information for payment. For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your information for regular health operations. For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and service we provide.

Business Associates: There are some services provided in our organization through contacts with Business Associates. Examples include data storage companies, collection agencies, and couriers. When these services are contracted, we may disclose your health information to our Business Associates so they can perform the job we've requested. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose relevant health information to a family member, relative, close personal friend, or any other person you identify - health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers whose research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose to the FDA health information related to adverse events with regard to product and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacement.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Correctional institution: Should you be an inmate of a correctional institution, we may disclose to the institution, or agents thereof, information necessary for your health and the health and that of other individuals.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority, or attorney, provided that a work force or a business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

DIAGNOSTIC IMAGING ASSOCIATES ♦ NOTICE OF HEALTH INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED, AND HOW YOU CAN ACCESS YOUR HEALTH INFORMATION. PLEASE REVIEW THIS DOCUMENT CAREFULLY.

INTRODUCTION

At Diagnostic Imaging Associates, P.A., we are committed to treating and using your protected heath information responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose this information. It also describes your rights as they relate to your protected health information. This notice is effective April 13, 2003, and applies to all protected health information as defined by federal regulations.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit Diagnostic Imaging Associates, a record of your visit is made. Typically, this record contains our symptoms, test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

Basis for planning your care and treatment, a means of communication among the many health professional who contribute to your care, a legal document describing the care you received, a means by which you or a third-party payer can verify that services billed were actually provided, a tool in educating health professionals, a source of data for medical research, a source of information for public health officials charged with approving the health of this state and the nation, a source of date for our planning and marketing, a tool we can assess to help us continually improve the care we render and the outcomes we achieve.

Understanding what is in your medical record and how this information is used helps you: ensure its accuracy, better understand the circumstances under which health information can be accessed and make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of Diagnostic Imaging Associates, the information belongs to you. You have the right to:

- Obtain a paper copy of this Notice of Information Practices upon request
- Inspect and copy your health record as provided for in 45 CFR 164.524
- Amend your health record as provided in 45 CFR 164.528
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- Request communications of your health information by alternative means or at alternative locations
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

OUR RESPONSIBILITIES

Diagnostic Imaging Associates is required to:

- Maintain the privacy of your health information
- Provide you with this notice of our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

Diagnostic Imaging Associates reserves the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will send a revised notice to the preferred mailing or e-mail address you've supplied us.

Diagnostic Imaging Associates will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue use or disclosure of your health information after we have received a written revocation of the authorization according to the procedures included in this authorization.

See Other Side