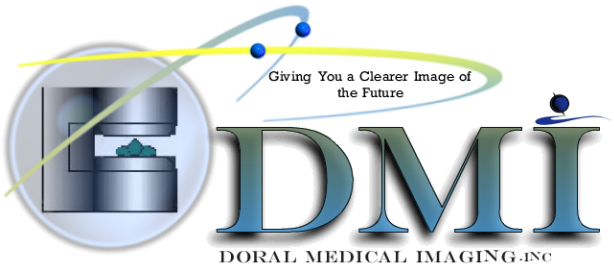
Internal Use Only

Chart Number # _____



ASSIGNMENT OF RIGHTS

For treatment provided and other good and valuable consideration I,_____ (hereinafter patient), hereby assign all rights that PATIENT has under any group health, HMO plan, individual health, PIP, disability or any other health or medical insurance policy or reimbursement plan that may pay patient benefits for services and treatment that_____has received or will receive from Doral Medical Imaging, Inc.

This assignment includes but is not limited to all rights to proceed against _____ insurance company or HMO in any action including legal suit if or any reason_____insurance company or HMO fails to make payments of benefits to which is due. This assignment also includes any right to recover attorneys fees and costs for such action brought by the provider as_____assignee.

_____

PATIENT NAME

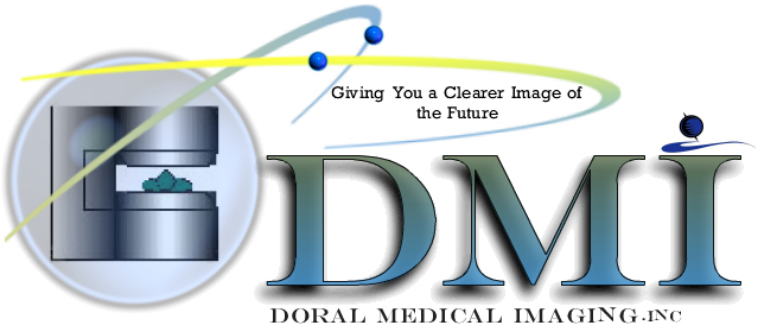
_____ _____

PATIENT SIGNATURE DATE

_____ _____

WITNESS DATE

Internal Use Only
Chart Number # _____



AFFIDAVIT OF NON-OWNERSHIP RESIDENT RELATIVE'S INSURANCE COMPANY

I,_____ was involved in motor vehicle accident occurring on_____ . At the time of said accident, I did not own a motor vehicle nor anyone in my household owned a motor vehicle for which security was required by Florida law.

Date this: _____

Patient Signature: _____

STATE OF FLORIDA

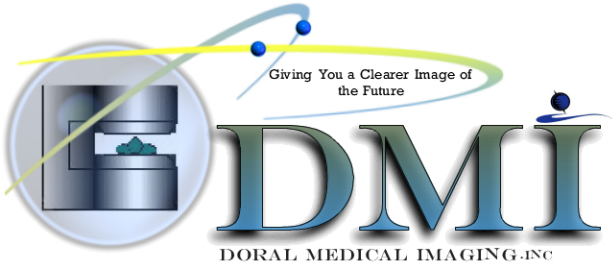
COUNTY OF DADE

The foregoing instrument was acknowledge before me this Day of _____, 2006 by_____ who showed _____ as identification.

NOTARY INFORMATION

_____
Signature

_____ _____
Printed Name My Commission Expires



Internal Use Only
Chart Number # _____

BILLING INFORMATION SHEET

PATIENT INFORMATION

Patient's Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone Number: _____ Cell#: _____
Social Security Number: _____

Employer Information

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone: _____
Contact Person: _____

Insurance Carrier Information

Insurance Name: _____
Billing Address: _____
City: _____ State: _____ Zip: _____
Policy Number: _____
Claim Number: _____
Prior Authorization Number (If Applicable): _____

Insured's Information (If Different than patient)

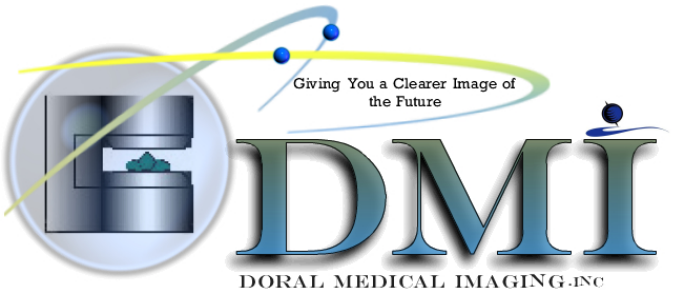
Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone Number: _____
D.O.B.: _____
Patient relationship to insured: _____

Date of Accident: _____

Kind of accident: _____

Referring Physician: _____

Telephone # _____



Internal Use Only
Chart Number # _____

INSTRUCTIONS FOR PAYMENT

I, _____ hereby direct, _____ to make payment directly to Doral Medical Imaging, Inc. for the medical bills I incur during the course of my treatment with same. I specifically instruct you to send payment to Stat Diagnostic Imaging, Inc. at the following address: 8181 NW 36 ST Suite 3, Miami, FL 33166.

I understand that I am financially responsible for charges for services not covered by this authorization. If for any reason, my insurance claim is denied or only a portion is paid by my insurance company, I understand that I am still liable for any outstanding balance.

In the event your policy is to mail payment directly to the medical provider, I specifically authorize and direct you to make payment to me at the following address:

C/O Doral Medical Imaging, Inc.
8181 NW 36 ST Suite 3
MIAMI LAKES, FL 33166

_____
Patient Name

_____
Patient Signature

_____ _____
Witness Date

This is an instruction of payment by the patient/your insured which in no way violates the patient's policy agreement between the patient and your company.

You, the insurance company are herby set on notice to obey and follow the patient/your insured's instructions for payment.

Pursuant to F.S. 627.736(4), you are herby instructed to pay this claim within thirty (30) days of receipt. Also, pursuant to this statue, interest will accrue on any unpaid medical bills at the rate of 10% per annum.

Internal Use Only

Chart Number # _____

LIABILITY RELEASE

I understand that undergoing through a Magnetic Resonance Imaging (MRI/CT/X-Ray) test is not recommended for pregnant women. . I have been advised by the personnel at Doral Medical Imaging, Inc. that a pregnancy test should be done prior to proceeding with an M.R.I. in order to rule out any possibility of pregnancy.

I refuse or do not believe such pregnancy test prior to undergoing an M.R.I/CT/X-Ray necessary.

Furthermore, I release Doral Medical Imaging, Inc., its officers, employees, and any other personnel involved in the performance of the M.R.I. from any damages or expense arising as a result of the above.

_____

Patient Name:

_____

Patient Signature:

_____

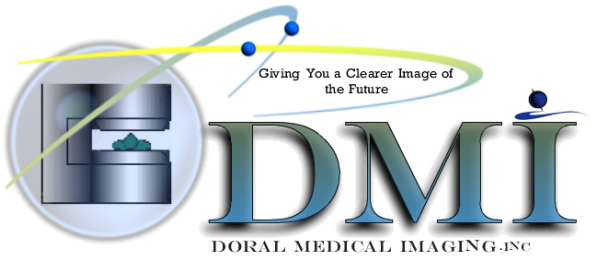
Witness:

_____

Witness:

_____

Date:



Internal Use Only
Chart Number # _____

MEDICAL RECORDS & RELEASE FORM

Patient Name: _____ Sex: _____ S.S.#: _____
D.O.B.: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone: _____ Cell #: _____
Employer: _____ Telephone: _____

Ordering Physician: _____
Type of Case: _____ Date of Accident: _____
Name of Insured: _____ Relationship to insured: _____
Insurance Carrier: _____ Policy Number: _____
Address: _____
City: _____ State: _____ Zip: _____
Claim Number: _____
Adjuster: _____ Telephone: _____

Attorney Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone: _____ Fax#: _____

Co-Insurance Carrier: _____ Policy: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone: _____ FAX#: _____
Adjuster: _____

Date Of Exam:_____ Time: _____

1-Exam Requested: _____
CPT Code: _____ Diagnosis: _____

2-Exam Requested: _____
CPT Code: _____ Diagnosis: _____

Patient Authorization to Release Medical Records

I authorize the release of any information, Including medical information and records needed to process claims for services rendered to me by Doral Medical Imaging, Inc.. I also request payment of benefits directly to Doral Medical Imaging, Inc.,

_____ _____
Patient Signature Date

Internal Use Only
Chart Number # _____

M.R.I. / C.T. TECH SHEET

PATIENT INFORMATION

Patient Name:_____ S.S. #: _____
Patient Address: _____
D.O.B.: _____ Weight: _____ Height: _____
City: _____ State: _____ Zip: _____
Telephone-1: _____ Cell#: _____
Allergies: _____

SCAN INFORMATION

Case Type:_____

Type of Scan - 1: _____

Diagnosis: _____

Type of scan – 2: _____

Diagnosis: _____

Type of scan – 3: _____

Diagnosis: _____

SEQ. PLANE	T.R.	T.E.	MATRIX	RES.	F.O.V.	NEX	SLICE THICK

Comments & Other Data: _____

☐ YES ☐ NO Copies were given to patient

_____ _____
Technologist Date

Internal Use Only

Chart Number # _____

Giving You a Clearer Image of the Future

DMI

DORAL MEDICAL IMAGING, INC

NOTICE OF LIEN

(Letter of Protection)

I, _____, authorize Doral Medical Imaging, Inc., to furnish my attorney, with a full report of the services that Doral Medical Imaging, Inc. has provided to me as prescribed by my physician_____, with regards to the accident in which I have been involved.

I hereby authorize and direct my attorney, _____to pay directly to Doral Medical Imaging, Inc., such sums as may be due and owing Doral Medical Imaging, Inc., for neurological examinations, evaluations and or diagnostic tests rendered to me. I further authorize and direct _____ to withhold such sums from any settlement, judgment or lien as may be necessary to protect Doral Medical Imaging, Inc., against any and all proceeds of my settlement, judgment or verdict which may be paid to _____or to me as a result of the injuries for which I have been treated in connection therewith.

I agree never to rescind this document and that a revision will not be honored by my attorney _____. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable on the case as if it were executed by him.

I fully understand that I'm directly and fully responsible to Doral Medical Imaging Inc., for all bills submitted by them for services rendered to me and that this agreement is made solely for the additional protection of Doral Medical Imaging, Inc., and in consideration for their awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may recover such fee.

Patient: _____ Date: _____

The undersigned, attorney of record for _____does hereby agree to observe all of the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to protect Doral Medical Imaging, Inc. I, _____further agree that in the event this lien is litigated, the prevailing party will be awarded attorney's fees and costs.

Attorney: _____ Date: _____

Internal Use Only
Chart Number # _____

PATIENT INTERVIEW CHECKLIST

Conformation

- ☐ AFFIDAVIT OF NON OWNERSHIP
- ☐ BILLING INFORMATION SHEET (ALL, EXCEPT W/C)
- ☐ INSTRUCTIONS FOR PAYMENT (ALL)
- ☐ MEDICAL RECORDS & RELEASE FORMS
- ☐ MRI/CT TECH SHEET (ALL)
- ☐ NOTICE OF LIEN (AUTO/SLIP & FALL CASES ONLY)
- ☐ ASSIGNMENT OF RIGHTS (ALL)
- ☐ CONTRAST RELEASE FORM (FOR CONTRAST PATIENT ONLY)
- ☐ LIABILITY RELEASE (FEMALE PATIENTS ONLY)
- ☐ MRI PATIENT INTERVIEW (ALL)(FOR MRI/CT PATIENTS ONLY)
- ☐ NOTICE OF INITIATION OF TREATMENT
- ☐ DO YOU ANY METAL IMPLANTS IN YOUR BODY
- ☐ ARE YOU PREGNANT (FEMALE ONLY)
- ☐ HAVE YOU EVER HAD AN ALERGIC REACTION TO CONTRAST
- ☐ DISCLOSURE OF HEALTH INFORMATION (ALL)
- ☐ DISCLOSURE AND ACKNOWLEGGMENT FORM (AUTO ONLY)

_____
Patient Signature

_____ _____
Witness Date