

## 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.

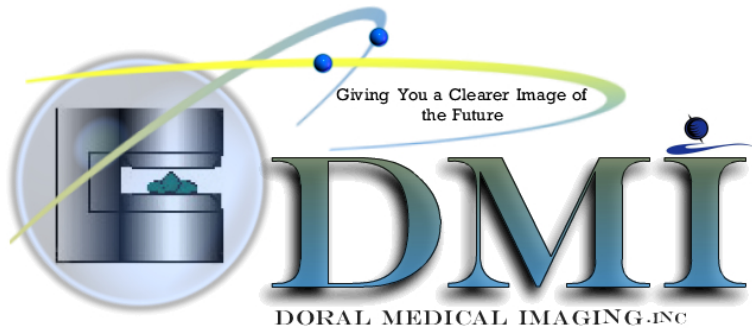
\_\_\_\_\_  
PATIENT NAME

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
DATE



**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.

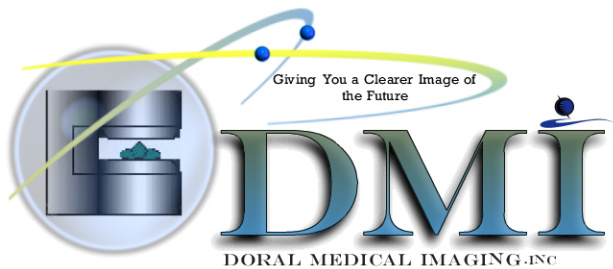
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NOTARY INFORMATION

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
My Commission Expires



Internal Use Only  
Chart Number # \_\_\_\_\_

## **BILLING INFORMATION SHEET**

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### **PATIENT INFORMATION**

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

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### **Employer Information**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone: \_\_\_\_\_  
Contact Person: \_\_\_\_\_

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### **Insurance Carrier Information**

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

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### **Insured's Information (If Different than patient)**

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

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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

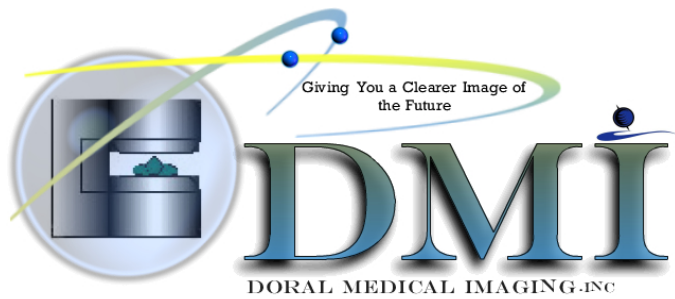
\_\_\_\_\_  
Witness

\_\_\_\_\_  
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 hereby set on notice to obey and follow the patient/your insured's instructions for payment.

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



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.

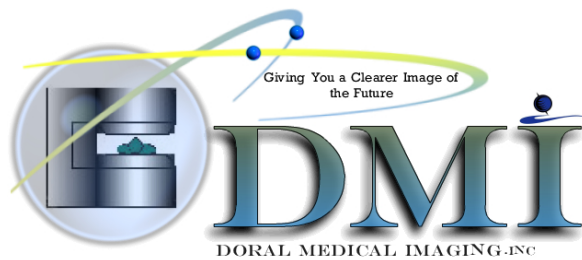
\_\_\_\_\_  
Patient Name:

\_\_\_\_\_  
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: \_\_\_\_\_

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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: \_\_\_\_\_

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Attorney Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Telephone: \_\_\_\_\_ Fax#: \_\_\_\_\_

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

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Date Of Exam: \_\_\_\_\_ Time: \_\_\_\_\_

1-Exam Requested: \_\_\_\_\_  
 CPT Code: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

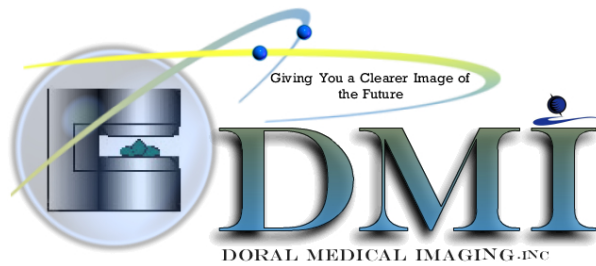
2-Exam Requested: \_\_\_\_\_  
 CPT Code: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

**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 Dorai Medical Imaging, Inc.. I also request payment of benefits directly to Dorai 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: \_\_\_\_\_

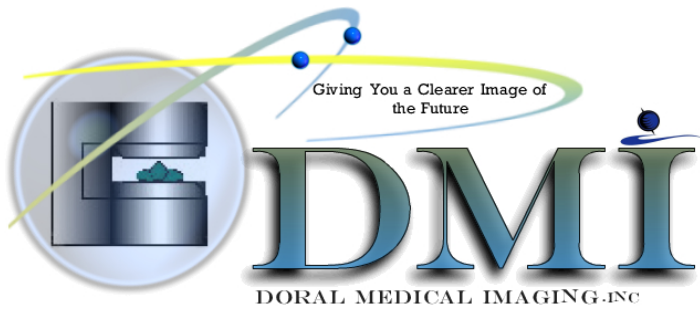
SEQ. PLANE	T.R.	T.E.	MATRIX	RES.	F.O.V.	NEX	SLICE THICK

Comments & Other Data: \_\_\_\_\_

YES     NO    Copies were given to patient

\_\_\_\_\_  
 Technologist

\_\_\_\_\_  
 Date



## NOTICE OF LIEN (Letter of Protection)

I, \_\_\_\_\_, authorize Dorol Medical Imaging, Inc., to furnish my attorney, with a full report of the services that Dorol 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 Dorol Medical Imaging, Inc., such sums as may be due and owing Dorol 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 Dorol 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 Dorol 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 Dorol 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 Dorol 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: \_\_\_\_\_



## 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 ACKNOWLEDGMENT FORM (AUTO ONLY)

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date