



7050 NW 4th Street Suite 303
Plantation Florida 33017
Tel: 754 778 8882
Fax: 954 703 1804

Today's Date / Fecha

mm dd yy

Personal Information / Informacion Personal

First Name / Primer Nombre		Last Name / Apellido		DOB / Fecha Nacimiento		SSN / Numero de Seguro Social	
				mm dd yy			
Address / Direccion						Apt / Apartamento	
City / Ciudad				State / Estado		Zip Code /Codigo Postal	
Home # / Numero de Casa			Work # / Numero de Trabajo			Cell # / Numero Celular	
Sex / Sexo: ☐ F ☐ M		Marital Status / Estado Civil				☐ S ☐ M ☐ W ☐ Sep ☐ D	
Emergency Contact / Contacto de Emergencia				Telephone # / # Telefono		Email Address / Correo Electronico	
Primary Doctor / Medico Primario				Telephone # / Numero de Telefono			
Referring Physician / Medico Referente				Telephone # / Numero de Telefono			
Employer Information / Informacion Trabajo				Telephone # / Numero de Telefono			
Primary Insurance HMO ☐ PPO ☐ MEDICARE ☐ MEDICAID ☐ W/C ☐							
Name of Insured / Nombre de Asegurado				Authorization # / Numero de Autorizacion			
ID# / Numero de Asegurado				Authorization # / Numero de Autorizacion			
Secondary Insurance HMO ☐ PPO ☐ MEDICARE ☐ MEDICAID ☐ W/C ☐							
Name of Insured / Nombre de Asegurado				Authorization # / Numero de Autorizacion			
Medical Center Policies							
A. Please alert our office of any insurance or address changes. B. If you are on HMO or on an insurance company that requires authorization for your test, please make sure the authorization has been received. C. It is your responsibility to know if your insurance has specific rules or regulations, such as the need for referrals from a physician, pre-certification, and limits on outpatient charges. You should be knowledgeable of any deductibles, copayments, and/or coinsurance the responsibility for payment of fees for services is the direct responsibility of the patient. D. Your health benefit plan is an arrangement between you, the enrollee, and the insurance company, HMO, or your employer. Your health benefit plan determines your coverage, requirements, and establishes the limit on your coverage for medical services. Based on what they determine is medically necessary. However, we will do our best to assist you with understanding your proposed treatment and an answering questions related to your insurance. E. All results will be sent to your referring physician within 48-72 hours. F. Co-payments and deductibles are due at the time of service. Patients with imput or comments, please feel free to write to us at 7050 NW 4th Street, Suite 303, Plantation FL. 33017							



7050 NW 4th Street Suite 303
Plantation Florida 33017
Tel: 754 778 8882
Fax: 954 703 1804

Your Rights

Right to inspect or copy your PHI: Under federal law, however, you may not inspect or copy information, compiled in reasonable anticipation of, or in use in, a civil, criminal, or administrative action, or proceeding, and protected health information. that is subject to law that prohibits access.

Right to request restriction of your PHI: You may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment, or operations. You may also request that any part of your protected health information not be disclosed to family members or friends, who may be involved in your care, or for notification purposes as described in the notice of Privacy Practices. Your request must be in writing, and must state the specific restrictions requested and to whom you want the restrictions to apply. The facility is not required to agree to a restriction that you may request. If the Medical Director or his appointees believe it is in your best interest to permit use and disclosure of your protected health information, your PHI will not be restricted.

Right to alternative communications: You have the right to request to receive confidential communications from us by alternate means or add the alternative location.

Right to obtain a paper copy: Upon request, even if you have agreed to accept this notice alternatively, i. e., electronically.

Right to amend your PHI: The facility has the right to deny your amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us, and we may prepare a rebuttal to your statement and will provide you a copy of any such rebuttal.

Right to accounting disclosures: You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

You may complain to us or to the Secretary of the Department of Health and Human Services, if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint, we will not retaliate against you for filing a complaint.

This notice was published and becomes effective on / before April 14, 2004.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our duties and privacy practices with respects to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you received this Notice of Privacy Practices.

Print Name

Signature

Date

Ultrasound History & Screening Form

Date: ____/____/____ Patient: _____ Sex: M F

Age: _____ DOB ____/____/____ Weight: _____ Height: _____

*****Female Patients Only*****

First day of Last Menstrual Cycle: _____

How many times have you been pregnant? _____

How many children have you delivered? _____

Why are you having this test today?

Have you had previous imaging related to this problem? Yes: _____ No: _____

If Yes, where was the exam performed? _____

List any other medical problems: _____

List all previous surgeries: _____

List all allergies: _____

Technologist Notes: _____

I have answered these questions to the best of my knowledge and understand the information presented to me.

Date: _____

Patient/Parent/ Legal Guardian Signature

Date: _____

Technologist Signature

Radiology Diagnostic Medical Imaging LLC
7050 NW 4th Street
Suite 303
Plantation, FL 33317
754-778-8882

Informed Consent for Ultrasound / Sonogram

Patient Name: _____ DOB: _____

Your physician has requested that we perform an ultrasound/sonogram (US) to obtain additional information. This is a diagnostic test that uses sound waves and a computer to produce images of internal body parts.

The benefit of this exam is to assist your physician with making a diagnosis. There may be other imaging alternatives, however, your physician believes that a sonogram to be the best diagnostic test for you after evaluating your symptoms and medical condition at this time.

By my signature below, I hereby certify that I have fully read this consent, had it explained to me or have had it read to. I have been given an opportunity to ask questions about my condition, alternative forms of treatment, the procedures to be used, and the risks and hazards involved. I understand its contents and have sufficient information to give this informed consent.

Date: _____
Patient/ Parent/ Legal Guardian Signature

Date: _____
Technologist Signature

Additional Technologist Notes