OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

_____

_____

2. I have the right and the **duty to confirm** that the services have already been provided.

3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.

4. The medical provider has **explained** the services to me for which payment is being claimed.

5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

_____	_____	_____
Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732(14) and (15), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her **own hand**)*:

_____	_____	_____
Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

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NOTICE OF PROVIDER LIEN

Patient Name: _____**DOB**: ____/____/_____Date of Injury:_____/_____/_____

Attorney Name: _____Firm Name: _____

Address: _____City: _____ State: ____ Zip Code: _____

Phone: _____ Fax: _____ Email: _____

Auto Insurance Company: _____Adjuster's Name: _____

Policy #: _____Claim #: _____

Phone: _____ Fax: _____Email:_____

I authorize the release of all my protected health information in SimonMed Imaging's possession, including reports, images, billing records, to my attorney. I hereby release SimonMed Imaging and your employees from any and all liability for fulfilling the authorization request for release of medical information. I understand it is possible that the information in my medical records may be disclosed by the recipient to other parties. This consent will expire when the case settles. I have given my consent freely, voluntarily and without coercion. I may revoke this authorization at any time providing that I notify SMI Imaging, LLC, SimonMed Imaging, Inc., SimonMed Imaging, a professional corporation (collectively SimonMed Imaging) in writing to that effect. I understand that any releases, which were made prior to my revocation in compliance with this authorization, shall not constitute a breach of my rights to confidentiality. I understand that a photocopy/facsimile of this authorization is considered acceptable in lieu of the original.

I hereby authorize and direct you, my attorney, to: (1) withhold from any settlement, judgment or verdict resulting from the accident in an amount equal to any and all sums I owe to SimonMed Imaging for medical services provided to me by SimonMed Imaging; and (2) pay such sums directly to SimonMed Imaging. I hereby acknowledge that SimonMed Imaging has provided and/or will provide medical services to me as a result of such injury. I hereby further give a lien on my case to SimonMed Imaging against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney or myself, as a result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and solely responsible to SimonMed Imaging for all medical bills submitted for services provided to me, regardless of whether I receive any settlement, judgment or verdict as a result of the accident.

By signing and returning the below, I have been advised that if my attorney does not wish to cooperate in protecting the medical provider's interest, SimonMed Imaging will not await payment, but may declare the entire balance due and payable. I understand that a photocopy/facsimile of this authorization is considered acceptable in lieu of the original. Please date, sign, and return one copy to SimonMed Imaging and keep one copy for your records.

_____ Date: _____
Patient Signature

_____ Date:_____
Attorney Signature

The undersigned, being attorney of record for the above patient, does hereby agree to observe all terms of the above to pay SimonMed Imaging from any settlement, judgment or verdict.

Please email or fax signed Lien form to: Attorney@simonmed.com

WEST COAST
Phone: 602-749-8599
Fax: 602-302-5810

FLORIDA
Phone: 407-250-0947
Fax: 407-475-6810

ASSIGNMENT OF BENEFITS

I HEREBY ASSIGN AND TRANSFER ANY AND ALL RIGHTS, BENEFITS AND CAUSES OF ACTION TO SimonMed Imaging Florida, LLC. This is an assignment of any rights and benefits. In the event my insurance company is obligated to make payment to me upon charges made by the SimonMed Imaging Florida, LLC for its services and the company fails or refuses to make timely, complete payment I permit SimonMed Imaging Florida, LLC to prosecute said cause of action either in my name or under the SimonMed Imaging Florida, LLC name and further I authorize SimonMed Imaging Florida, LLC to compromise, settle or otherwise resolve said cause of action as they see fit.

DIRECTION OF PAYMENT

I hereby authorize and direct you, my insurance company and/or my attorney, to pay directly to SimonMed Imaging Florida, LLC, such sums as may be due and owing for the services rendered to me both by reason of accident or illness, and by reason of any other bills that are due SimonMed Imaging Florida, LLC I hereby authorize any insurance company to pay directly to SimonMed Imaging Florida, LLC the amount of this and/or any future bills for services rendered to me and to release any information requested that is pertinent to my case to my insurance company or attorney involved in this case.

LETTER OF PROTECTION IN FAVOR OF PROVIDER

I hereby authorize and direct that my lawyer, if I am represented by counsel, SHALL withhold such sums from any disability benefits, medical payment benefits, no-fault benefits, or any other insurance benefits obligated to reimburse me, or from any settlement, judgement or verdict on my behalf as may be necessary to reimburse SimonMed Imaging Florida, LLC for services provided to me I HEREBY FURTHER GIVE AN IRREVOCABLE LIEN to said SimonMed Imaging Florida, LLC against any and all insurance benefits name herein and any and all proceeds of any settlement, judgement or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by SimonMed Imaging Florida, LLC. In the event that I do not have insurance coverage, I understand that I remain personally responsible for payment of services rendered.

PIP LOG & DEC SHEET REQUEST

I hereby authorize SimonMed Imaging Florida, LLC to request a copy of the applicable insurance policy and declaration page which reflects the policy limits available at the time of the accident, and the applicable PIP loc to be provided to SimonMed Imaging Florida, LLC upon request. This request is

authorized pursuant to the terms of my policy as well as Florida Statutes. I hereby authorize SimonMed Imaging Florida, LLC to request and receive a copy of my PIP log periodically as they deem to be necessary.

RESERVATION OF BENEFITS

Be further advised that I am hereby placing you on notice pursuant to Florida case law that should you (the insurance company/carrier) deny, reduce or fail to pay any fart of, or an entire bill which was submitted on my behalf from this provider, I (The Assignor) as well as SimonMed Imaging Florida, LLC are requesting in advance that you reserve, or "set-aside" the amount you reduced or denied until the dispute is resolved. Should you submit a check to SimonMed Imaging Florida, LLC which is less than the correct contractual amount, and contains any language referring to payment as "full and final payment", I have instructed SimonMed Imaging Florida LLC to return the check to you (the carrier) and consider the bill still due and owning(i.e. a late payment as defined in F.S. 627.736). Additionally, should the remaining amount of my benefits approach an amount where there would be insufficient funds to pay the amount you reduced, denied or failed to pay, please notify me (the Assignor) AND SimonMed Imaging Florida, LLC of this fact. Should my benefits exhaust: please notify me (the Assignor) AND SimonMed Imaging Florida, LLC promptly.

SERVABILITY CLAUSE

If any term or provision of this Agreement, Lien and Authorization or the application thereof to any person or circumstances shall to any extent be invalid or unenforceable the remainder of this Agreement, Lien and Authorization, or the application of such term or provision to persons or circumstances other than those as to Which it is held invalid or unenforceable, shall not be affected thereby, and each term and provision of this Agreement, Lien and Authorization shall be valid and enforced to the fullest extent of the law.

PRINT
NAME:_____DATE:_____

SIGNATURE:_____

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Authorization to Release Protected Health Information

PLEASE FILL OUT EACH SECTION BELOW

PATIENT NAME: _____ MRN: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: X X X – X X – ____ ____ ____ ____

ALIAS/MAIDEN NAMES: _____ Phone: _____

To Disclose My Records: (Please check the exam(s) for which you are requesting reports/images)

- ☐ All Medical Records
- ☐ MRI
- ☐ PET
- ☐ CT
- ☐ X-Ray
- ☐ Dexa / Bone Densitometry
- ☐ Sonogram/Ultrasound
- ☐ Mammogram
- ☐ Nuclear Medicine
- ☐ Other: _____

Please provide a description of the exam you are requesting reports/films on (date, exam, body part):

_____

Are you requesting (check all that apply)**:** ☐ Report(s) ☐ CD ☐ Films

Please note, a $25.00 fee per set of films will apply. All films and CDs are promptly prepared at the time of pick up.

Please indicate how you would like these to be received:

☐ Fax to: _____ ATTN: _____

☐ Mail to: _____

☐ Email to: _____

☐ Collect in Person: *I understand that my records will only be provided to myself or any individual(s) I listed below. A photo ID is required at the time of pick up.*

By my signature below, I authorize SimonMed Imaging to release my protected health information to the following individual(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal and/or state privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, payment, eligibility for benefits unless allowed by law. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on the authorization. Unless otherwise revoked, this authorization will expire 1 year from date of signature. *You have the right to revoke this authorization, except to the extent the custodian of records has relied on it, by sending your written request to the Privacy Officer at: 6900 E. Camelback Road, #700 Scottsdale, AZ 85251*

_____ _____

Patient or Authorized Representative Signature | Date of Signature

_____ _____

Printed Name of Patient or Authorized Representative | Relationship to Patient

Phone: (866) 614-8555 Fax: (602) 302-5958

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CONSENT FOR MEDICAL TREATMENT **Arrival Time:** _____ **MRN:** _____

Patient Information – PLEASE PRINT

Patient Name (last name, first name): _____ ☐ **Male** ☐ **Female**

Date of Birth: _____ **Social Security *(optional)*:** _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:**

Home #: (_____)_____ **Cell #:** (_____)_____ **E-mail:** _____

Emergency Contact: _____ **Emergency Contact #:** _____

Medical History

Known Allergies: _____

Current Medications: _____

FEMALE Patients Only: Is there a possibility you may be pregnant? ☐ **YES** ☐ **NO** **Date of LMP:** _____

Insurance / Workers Comp Information / Guarantor

Primary Ins/Work Comp: _____ **Secondary Insurance:** _____ **Date of Injury:** _____
Insured (Insurance): _____ **Insured DOB:** _____ **Group#** _____ **Member ID#:** _____
Guarantor (Financially Responsible): _____ **Guar. DOB:** _____ **Relation to Patient:** _____ **Cell #:** _____
Address: _____ **City:** _____ **State:** _____ **Zip Code: :** _____

Patient's Authorized Representative

Please indicate with a YES or NO any authorized representative to whom we may release protected health information to, including any reports/films, insurance and or financial information. **If you are a parent or legal guardian, or have power of attorney over the patient, please list yourself below.*

Name: _____ **Relationship:** _____ **Phone #:** _____ ☐ **YES** ☐ **NO**

Telephone Consumer Protection Act Notice & Other Communication

➔ **INITIALS:** _____

In order to service your account or collect any amounts I may owe, SimonMed or its agents may contact me by telephone at any telephone number associated with my account, including without limitation wireless or cell phone numbers, which could result in a charge to me. You may also contact me using pre-recorded/artificial voice messages and/or through the use of automatic dialing devices. Additionally, I authorize the use of text messages and direct mail for appointment information and SimonMed promotions only.

Payment Policy

Please review our Payment Policy, should you have any questions, we may discuss prior to your exam. **Insurance**: We participate in most insurance plans, including Medicare. If you do not have insurance or are not insured by a plan we are contracted with, payment in full is due at the time services are provided unless prior arrangements have been made and agreed to in advance. **Proof of Insurance/Referral Forms**: We may require that you provide us with a copy of your driver's license and valid insurance card to provide proof of insurance. If we are not provided with the correct information, you may be held responsible for payment. If you do not have your insurance card, you will be responsible for payment at the time of service. Once we obtain your insurance information, we will bill the insurance company and refund any overpayments once the claim has been paid by your insurance plan. Inform us of any insurance changes made after this signed agreement/date of service. Insurance carriers have specific timely filing guidelines and pre-authorization requirements for certain services. If revised insurance information is not provided to us within insurances' timely filing limits, you will be required to pay for services in full. If prior authorization was required for services already received and your claim is denied for lack of authorization, you will be required to pay for services in full. **Co-Payments, Deductibles, & Coinsurance**: You agree to pay all co-payments, deductibles, and co-insurance at the time your exams are performed as required by your insurance plan. A time of service payment is an estimate of the amount due. The final amount due cannot be calculated until the claim is processed by your insurance company. Additionally, the estimate of the amount due at time of service may change over time due to deductible charges processed for other medical services rendered. **Non-Covered Services**: In some instances, the services you receive may not be covered or considered medically necessary by Medicare or other insurance plans. In these instances, you will be required to pay for these services in full at the time of your exam. Medicare patients may be required to complete a separate Advance Beneficiary Notice form in order for services to be rendered. **Assignment**: By signing this form, you agree to assign all insurance benefits to SimonMed Imaging for services performed and authorize SimonMed Imaging to submit a claim to Medicare or my insurance plan. We will submit your claim(s) to your insurance plan and will provide you with reasonable assistance to get the insurance plan to pay the claim(s). **Collections**: Once an account is placed in collection status, all future services must be paid in full at the time of service. There is a $25.00 fee for any returned checks. Patient payment policies may not be applicable in certain cases, including but not limited to workers compensation cases.

Notice of Privacy Practices & Patient Rights Acknowledgement

By my signature, I acknowledge receipt of the provider's Notice of Privacy Practices (HIPAA) and the provider's Patient Rights and have been given the opportunity to read them.

Release of / Request for Information Authorization

SimonMed Imaging may disclose all or part of the patient's medical and/or financial record to your insurance plan of benefit eligibility, to referring physicians, and to other healthcare providers responsible for providing continued patient care. We may request health information relating to imaging studies performed by SimonMed. This may include, but is not limited to, previous films, symptoms/history, laboratory results, pathology reports, etc. I understand that the above listed Patient's Authorized Representative will remain valid for 1 year (or until my next appointment) whichever is sooner. SimonMed Imaging may charge a fee of up to $25.00 for each set of requested films.

General Consent and Right to Refuse Treatment

General Consent to Treatment: By signing below, I (or my authorized representative on my behalf) authorize SimonMed Imaging, their staff, students, remote technologists and other collaborating healthcare professionals to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries. I understand that it is the responsibility of my individual treating healthcare provider(s) to explain to me the reason(s) for any particular diagnostic examination, test or procedure, the available treatment options and the common risks and benefits associated with these options as well as alternative courses of treatment. **Right to Refuse Treatment:** In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment or medication recommended or deemed medically necessary as prescribed by my referring physician. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as the results of my evaluation and/or treatment. *By signing below, I am stating that I understand and agree with the above policies and acknowledgement.*

Patient Signature: _____ **Date:** _____

Patient Signature: _____ **Date:** _____

Patient Signature: _____ **Date:** _____