ASSIGNMENT OF BENEFITS

RECORDS RELEASE, ASSIGNMENT OF BENEFITS, RESERVATION OF BENEFITS, REQUEST TO ESCROW DISPUTED BENEFITS RELATED TO PROVIDER'S CLAIMS, DURABLE POWER OF ATTORNEY TO NEGOTIATE INSURANCE PAYMENTS, LIEN ON PROCEEDS FOR SERVICES RENDERED AND GENERAL PATIENT RESPONSIBILITIES

RECORDS RELEASE: I authorize assignees to release any information pertinent to my case to any insurance company, adjuster, or attorney to facilitate collection under this Assignment, Lien, Reservation of Benefits and Authorization. I, hereby, authorize release of any and all medical information and/or records or previous films to Coastline Imaging, LLC., for the purpose of my diagnostic interpretation and verification of benefits.

ASSIGNMENT OF BENEFITS, RESERVATION AND REQUEST TO ESCROW ANY DISPUTED BENEFITS: Pursuant to Florida Statutes 627.736(5) I hereby assign my insurance benefits and any and all causes of action available under my policy of automobile insurance to Coastline Imaging, LLC., the Assignees. Additionally, both the assignees and the undersigned patient acknowledge they are foregoing or assuming certain rights under this agreement that they would not otherwise have under normal circumstances; and as such, agree the same serves as additional consideration for this assignment of benefits to the provider/assignees. In the event my insurance company, obligated to make payments to me upon charges made by assignees for services, refuses to make or reduces such payments and in order to maximize the benefits available under my policy coverage, I hereby request the insurance company (assuming there is coverage remaining at the time the company receives the Assignees' bill and if the company fails to pay Assignees the full amount of the bill(s) submitted), to avoid exhaustion of coverage while Assignees pursues its rights under this Assignment; both parties to this agreement **(the assignees and I) further authorize, direct, notice and request the Insurance Company to set aside and place in escrow an amount equal to the full amount of any such denial or reduction, and to hold that amount in escrow until the dispute is resolved in the appropriate forum.**

DURABLE POWER OF ATTORNEY TO NEGOTIATE INSURANCE PAYMENTS: I hereby grant Coastline Imaging, LLC Power of Attorney to endorse checks and/or to sign any piece of paper which will enhance or expedite payment to assignees for services rendered, including but not limited to a release of medical records and assignment of benefits/authorization to pay. Know by all these present that: The undersigned as made, constituted and appointed, and by these presents does hereby make, constitute and appoint Coastline Imaging, LLC and any of its duly authorized agents and employees as and to be the undersigned true and lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts or monies orders which are made payable to the undersigned alone or to the undersigned and Coastline Imaging, LLC which checks, drafts or money orders are made payable for services which have been made by Coastline Imaging, LLC at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft or money order.

Furthermore, the undersigned allows Coastline Imaging, LLC and any of its agents to sign any papers that will be necessary to enhance, expedite and/or allow payment to said provider. This may include affidavits of non-ownership of vehicles, insurance forms and other statements. The undersigned by these presents does give and grant Coastline Imaging, LLC as Attorney the full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the premises as fully to all intents and proposes as the undersigned might or could do, to personally present insofar as the endorsing and cashing of said checks are concerned as well as any other document. Hence, I agree that the above mentioned/Assignees be given Special Power of Attorney to endorse/sign my name on any and all checks and claim forms for payment of my bill, if any insurance draft arrives at the assignee's office drawn in my name or both names for payment of services rendered and submitted to the carrier. This durable power of attorney is not affected by subsequent incapacity of the principal except as provided in s. 709.08, Florida Statutes";

LIEN ON PROCEEDS FOR SERVICES RENDERED: I authorize you, my insurance company and/or my attorney, to pay directly to Coastline Imaging, LLC ("Assignees") all such sums as may be due and owing to the Assignees for services rendered, and to withhold such sums for any disability benefits, medical payments, No Fault benefits, or any other insurance benefits obligated to reimburse me for any claims, settlement, judgment, or verdict for me, as may be necessary to adequately protect said Assignees for payment for any services rendered. I give this lien to said Assignees for any and all insurance benefits and any and all proceeds of any settlement, judgment, verdict or other monies which may be paid to me as a result of the injuries or illness for which I received services by Assignees, to the extent they have provided services and remain unpaid for services provided.

GENERAL PATIENT RESPONSIBILITIES: I understand that I remain personally responsible for the total amounts due Assignees for their services as insurance coverage may only pay a certain percentage of the bill; as, I may have an insurance deductible or my insurance benefits may exhaust or otherwise be limited. I further understand and agree that this Assignment, Lien and Authorization does not require Assignees to await payments and they may demand payments from me immediately upon rendering services at their option, although the assignees agrees to first demand immediate payment from the insurance company as their first means of pursuing payment for services rendered. Also, I understand that if this account is assigned to an attorney for collection and/or suit, the assignees shall be entitled to reasonable attorney's fees and cost of collection. I also understand that if any bad check is written, I agree to pay for those added costs.
Please sign below stating that you agree to and understand the above. Also please note that the section regarding patient responsibility specifically applies to the portion of billing, if any, not paid by insurance because of deductibles or because of limits and / or exhaustion.

Patient's Signature ________________________________ **Witness**____________________________

Patient's Printed Name: **Dated this** ________**day of** ___________**20**_____

NOTICE OF PRIVACY PRACTICES

We are required by law to maintain the privacy of your medical information and to provide you with notice of our legal duties and privacy practices. We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change those terms and any changes made will be made available to you are our imaging facility or from our Privacy Coordinator by calling 321.253.2700 or by writing to: Coastline Imaging, LLC, Attn: Privacy Coordinator, 2290 W Eau Gallie Blvd, Suite 104, Melbourne, FL 32935.

MISSING PATIENT INFORMATION

We, at Coastline Imaging, LLC, are very aware of how challenging it can be to handle your medical and financial concerns following an accident or injury. Our staff has been trained to ensure that you receive the best care and information in both areas, so please feel free to ask any questions that you may have at any time. It is important to note that in order for us to comply with the Florida State Law and prevent you from potentially becoming wholly responsible for charges incurred, we must have your appropriate insurance information, Policy #, Claim # and/or Attorney information on file within 7 days of your visit to our facility. If we do not receive this information, your Insurance Company may have the right to deny coverage due to untimely filing which will result in complete financial responsibility to the patient.

Please contact our business office at 321.253.2700 to provide us with any additional information.

Patient Acknowledgement

I, ____________________________, hereby acknowledge that I have read and understand the information above. I have been given an opportunity to review the privacy practices at Coastline Imaging, LLC. I understand that I may obtain a copy of the Notice of Privacy Practices at any time. This notice has been issued and considered effective on the date signed. This form will be kept on file for a minimum of six (6) years.

____________________________ ________________

Patient Signature **Date**

CII

PATIENT HISTORY FORM

Patient Name ______________________ Sex ________ Date of Birth ____________ Age ______

Address ____

City / State / Zip ____

Mobile Phone ______________ Landline ______________ Email ____________________

Social Security # ____________________ Referring Physician ____________________________

Emergency Contact ____________________ Relationship ____________ Phone ______________
(Name and Last Name)

Injury Related? YES / NO Date of Injury ______________ AUTO WORK OTHER

Type of Injury / Symptoms ____

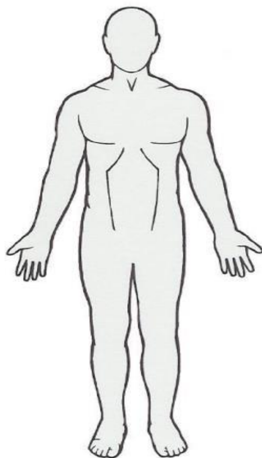
Previous surgery to area being scanned today? YES / NO Date/Description ______________________

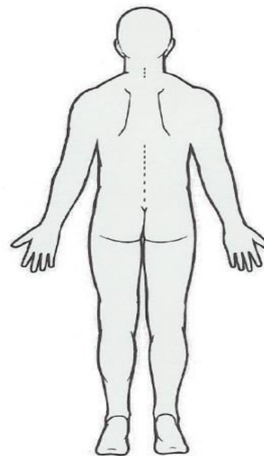
Do you have a personal history of cancer? YES / NO If YES, indicate type ______________________

Do you have a personal history of diabetes? YES / NO ______________________________

Please indicate areas of pain (X), numbness (O), other (+)

RT - FRONT - LT LT - BACK - RT





PATIENT SIGNATURE: ________________________________ Date ____________
Guardian (if minor)

Date of Next Appointment: ___________________________

MRI SCREENING FORM

Patient Name:_______________________________ DOB:________________ Height: _____________ Weight: _________

Screening Date: _____________________________ Staff: ______________ **CII**

Are you Claustrophobic	Yes ☐ No ☐
Body piercing, tattoos, hair extensions, wigs, weaves	Yes ☐ No ☐ Remove ALL piercings, extensions, wig
Brain aneurysm clip	Yes ☐ No ☐
Cardiac pacemaker, pacer wires, or implanted Defibrillator (ICD)	Yes ☐ No ☐
Dental or partial dental plates / Implants / braces	Yes ☐ No ☐
Electronic or mechanical activated implant or device	Yes ☐ No ☐
Eye or ear implant, cochlear implant, spring or wires, hearing aids	Yes ☐ No ☐
HBP or Diabetes / Medication or Glucose patch	Yes ☐ No ☐
Heart Valve repair or replacement	Yes ☐ No ☐
Implanted orthopedic item - hip, knee, pins, rods, screws	Yes ☐ No ☐
Have your eyes being exposed to grinding metal or metal slivers?	Yes ☐ No ☐
Prosthetic Limb (Arm or Leg)	Yes ☐ No ☐
Insulin or medication infusion pump	Yes ☐ No ☐ If yes, is it removable?
M: Penile implant/prosthesis // F: Breastfeeding - IUD - Pregnant	Yes ☐ No ☐
Capsule Endoscopy/ Colonoscopy	Yes ☐ No ☐ If yes, MRI needs to be done after 6 weeks
Metallic fragment or foreign body (ie. shrapnel, BB or bullet)	Yes ☐ No ☐
Neurostimulator (brain, spine, bone, etc)	Yes ☐ No ☐
Stent, IVC filter or aneurysm coil, or shunt (spinal or interventricular)	Yes ☐ No ☐ If yes, specify type & which body part?
Surgical staples, clips, or metallic sutures	Yes ☐ No ☐
Wheelchair / Cane / Walker	Yes ☐ No ☐

List ALL Surgeries: ____

____

Previous scans done on the area we are scanning Today? Date and Location: ______________________________

____ **REQUESTED: ☐ YES ☐NO**

I attest the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MRI procedure that I am about to undergo.

Patient/ Guardian Signature: ____________________________________ Date: ______________________

Print Name: _________________________________ Relationship to Patient: ________________________

Date of Next Appointment: ___________________________

MRI SCREENING FORM

Patient Name:________________________________ DOB:________________ Height: _____________ Weight: _________

Screening Date: _____________________________ Staff: ______________ **CII**

Are you Claustrophobic	Yes ☐ No ☐
Body piercing, tattoos, hair extensions, wigs, weaves	Yes ☐ No ☐ Remove ALL piercings, extensions, wig
Brain aneurysm clip	Yes ☐ No ☐
Cardiac pacemaker, pacer wires, or implanted Defibrillator (ICD)	Yes ☐ No ☐
Dental or partial dental plates / Implants / braces	Yes ☐ No ☐
Electronic or mechanical activated implant or device	Yes ☐ No ☐
Eye or ear implant, cochlear implant, spring or wires, hearing aids	Yes ☐ No ☐
HBP or Diabetes / Medication or Glucose patch	Yes ☐ No ☐
Heart Valve repair or replacement	Yes ☐ No ☐
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M: Penile implant/prosthesis // F: Breastfeeding - IUD - Pregnant	Yes ☐ No ☐
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Surgical staples, clips, or metallic sutures	Yes ☐ No ☐
Wheelchair / Cane / Walker	Yes ☐ No ☐

List ALL Surgeries: ____

____

Previous scans done on the area we are scanning Today? Date and Location: _______________________________________

____ **REQUESTED: ☐ YES ☐NO**

I attest the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MRI procedure that I am about to undergo.

Patient/ Guardian Signature: ____ Date: _________________________

Print Name: _______________________________________ Relationship to Patient: ___________________________

PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS & PROTECTED HEALTH INFORMATION

Patient Name: ________________________________ **DOB:** ______________________

Address: ____

City/State/Zip:____

Phone: ______________________________ **Email:** ________________________________

I hereby authorize to release my protected health information in the manner listed below:

(RELATIVES ONLY / Doctors do not apply) Last, First Name: _____________________________________

<u>From / To the following:</u> (Facilities/Doctor)

Name: ____

Send to: Coastline Imaging, LLC
Fax: (321) 253-2267

______ **ALL RECORDS**

______ **SPECIFIC ITEM:** ________________________

Patient's Signature: ___________________________________

Patient's Name (Print): _______________________________ **Date:** ________________