4373 West Sunrise Blvd.

Patient Checkin and Intake Document

Demographic Information

Firstname	Robert	**Lastname**	**Patient**
Email	service@itpacspro.com	**Mobile**	**(305)992-1500**
Date of Birth	1955-01-01	**Gender**	**M**
Address1	350 Main Street	**Address 2**	
City	MIAMI	**State**	Florida
Country	United States	**Postal code**	33015
SSN		**Weight**	190

COVID Questions

- Question: Have you traveled locally or internationally within the last 14 days ?
- Answer:

- Question: Have you come into close contact with someone who has a laboratory confirmed COVID-19 diagnosis within the last 14 days ?
- Answer:

- Question: Do you have a fever(greater than 100.4 F or 38.0 C) OR any of these symptoms listed below?
- Answer:

- Question: Have you experience any of these SYMPTOMS in the last 14 days ?
- Answer:

- Question: Is this visit related to AUTO ACCIDENT?
- Answer:

- Question: Is this visit related to SLIP AND FALL?
- Answer:

- Question: Previous Exam at Plantation?
- Answer:

- Question: CLINICAL HISTORY Why you are having this exam?
- Answer:

- Question: Select any ALERT you may have?
- Answer:

- Question: Do you have any MEDICAL HISTORY ? If Yes describe below.
- Answer:

- Question: Are you currently taking any MEDICATION ?
- Answer:

- Question: Do you have any type of implants?
- Answer:

- Question: Is there any possibility your implant may be made of Metal?
- Answer:

CONSENT TO PERFORM DIAGNOSTIC TESTING : I hereby authorize POM MRI and Radiology Center of Plantation to

perform diagonstic testing on myself or my minor/dependent.

RELEASE OF MEDICAL INFORMATION: I hereby authorize POM MRI and Radiology Center of Plantation to release information from my patient medical records. This authrization, or photocopy thereof, will authorize the release of full and complete medical records when necessary to authorized healthcare providers, hospitals, and.or insurance companies. I understand that i may revoke this authorization, in writing ,at any time. I understand that a revocation is not effective to the extent that any person(s) and/or organization(s) involved in my care have already acted in reliance on my authorization. I have read and understand the contents of this authorization and confirm that they are consistent with my direction.

ASSIGNMENT OF CLAIM AUTHORIZATION: I hereby authorize the direct payment of medical benefits to POM MRI and Radiology Center of Plantation . This authorization, or photocopy thereof, will authorize direct payment of medical benefits to POM MRI and Radiology Center of Plantation I understand that I am financially responsible for charges not covered by this authorization.

RECEIPT OF NOTICE OF PRIVACY PRACTICES: A copy of the "Notice of Privacy Practices" has been made available to me for reading and/or copy, as well as being posted for my viewing from POM MRI and Radiology Center of Plantation concerning how the use or disclosure of protected health information will be handled by the our center. A personal copy can be made if requested.

CD AND FILM POLICY

Please use this form as authorization to send copies of my medical reports and records to the following physician(s) office(s):

CD & Film Policy:

POM MRI and Radiology Center of Plantation will have a copy of your report faxed to your healthcare physican, as named above, usually within 48 hours. If you require a copy of the

report to be sent to second physician, such as specialist, please provide that information as well.

Generally, your healthcare provider will only require a signed copy of the radiologist;s report. For more extensive stucdies, such as MRI,CT or PET/CT, your healthcare provider may request that you bring copies of the images for further evaluation. If these images are needed, please let us know. We will provide digital images on a CD at no charge to you. For other studies, such as X-rays, ultrasounds, bone density scans, or any other exams not already listed, please have your healthcare provider(s) office call 954-900-2020', ext 247, and request the images. These will be ready for pickup within 48 hours.

Patient requesting copies of images for their own use may do so in writing, Please allow 48 hours to process the request. The first copy is free and second copy is $.

I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION IN WRITING AT ANY TIME, EXCEPT TO THE EXTENT THAT THE PERSON(S) AND OR ORGANIZATION(S) NAMED ABOVE, HAVE TAKEN ACTION IN RELIANCE ON THIS AUTHORIZATION, THIS AUTHORIZATION WILL EXPIRE 90 DAYS FROM THE DATE SIGNED, OR IN THE EVENT THAT A WRITTEN REVOCATION IS RECEIVED, WHICHEVER COMES FIRST.

Robert Patient
Signature