Phone: 818-907-7723
www.PreciseMRI.com

**ANY PAPER FORMS FILLED OUT, PLEASE UPLOAD VIA FRONT DESK PORTAL @ App.RadFlow360.com/front-desk**

****USE THE INCLUDED PATIENT ID AND ACCESSION # IN YOUR SYSTEM/PACS****

| | | | |
|---|---|---|---|
| **NAME** | **LAST:** BELL | **FIRST:** VICTORIA LATOYA | **ID:** PRE1048455 |
| **PHONE** | **HOME:** () - | **Cell:** (415) 572-0808 | **DOB:** 10/25/1983 |
| **PATIENT ADDRESS** | 1495 TREAT WAY, SAN FRANCISCO, CA 94110 | | |
| **CLINICAL HISTORY** | None | | |
| **REFERRING PHY** | NIMA HOSSEINI | | |
| **EXAM LOCATION** | 1180 Post St., San Francisco CA | | |

**Patient ID : PRE1048455** ****USE THE INCLUDED PATIENT ID AND ACCESSION # IN YOUR SYSTEM/PACS****

| ACCESSION | EXAM | CPT | DX | READ TYPE | DATE / TIME |
|---|---|---|---|---|---|
| RAM1040439 | MRI HIP W/O CONTRAST - LT - RESOURCE: OPEN MRI | 73721 | M25.552 | Tech Only | 7/5/2025 10:00:00 AM |

**PLEASE HAVE PATIENT WALK OUT W/ CD**

## 1) HAVE PATIENT FILL OUT ALL FORMS (IF ANY)
## 2) Obtain photo ID, ONLY if not already in the front desk portal.
## 3) PHOTO ID & ANY PAPER FORMS FILLED OUT, PLEASE UPLOAD VIA THE FRONT DESK PORTAL @ App.RadFlow360.com/front-desk

**? HAVE A QUESTION? LIVE CHAT WITH US VIA FRONT DESK PORTAL ?**

**Patient can upload photo ID, e-sign liens and view appointments @ App.RadFlow360.com/patient-portal**

**Generated on : 6/17/2025 9:40:32 PM**

Precise Imaging **FAX TO 888-777-4356**

## PATIENT INFORMATION

| | | |
|---|---|---|
| **Social Security Number:** | | **DOB:** 10/25/1983 |
| **Patient Name** (Paciente): | BELL, VICTORIA LATOYA | **ID: PRE1048455** |
| **Address** (Domicilio): | 1495 TREAT WAY, SAN FRANCISCO, CA 94110 | |
| **Tel #** (Telefono): | **Home:** () - | **Cell:** (415) 572-0808 |
| **Why are you here today & what are your symptoms?** (Por que esta aqui y cuales son sus symtomas?): | | |

## ATTORNEY INFORMATION

| | | | |
|---|---|---|---|
| **Attorney Name** (Abogado): | UNITED CITIZEN LAW | | |
| **Address** (Direccion): | 3400 WATT AVE STE 200A,SACRAMENTO, CA 95821 | | |
| **City, State, Zip** (Ciudad), (Estado), (Codigo): | SACRAMENTO, CA 95821 | | |
| **Tel#** (Telefono): | (916) 800-8457 | **Fax:** (916) 352-8603 | |
| **Driver's Name** (Conductor): | | **Date of Injury** (Fecha de Herida): | |

## AUTO INSURANCE INFORMATION

| | | | |
|---|---|---|---|
| **Insurance Carrier** (compañía de seguros): | | | |
| **Adjuster** (Ajustador): | | **Claim #** (# de Reclamo): | |

***If you were in a car accident, please put the name of the person driving the car YOU were in. If you were the driver, please put your own name. (Si esto es un caso de un accidente de auto y usted fue pasajero, pon el nombre de conductor del auto que viajaba usted. Si usted era el conductor, pon su nombre)**

Sign(Firma): _____ Date(Fecha): _____

PRE1048455^019

**6710 Kester Ave. #126, Van Nuys, CA 91405**
**Office: 818-907-7723 Fax: 888-715-7001 www.PreciseMRI.com**

**SSK MD Inc.**

**Email Signed Lien To : docs@medbillingservice.net**

**PERSONAL INJURY MEDICAL RADIOLOGIST LIEN**

**TO THE LAW OFFICE OF:**

UNITED CITIZEN LAW
3400 WATT AVE STE 200A
SACRAMENTO, CA 95821

Tel: (916) 800-8457

**BELL, VICTORIA LATOYA**

**PRE1048455** **DOB: 10/25/1983**

*** * * INFORM YOUR ATTORNEY OF ALL PROCEDURE(S) DONE WITH SSK MD Inc. TO ENSURE SERVICES ARE PAID THROUGH YOUR CASE. FAILURE TO INFORM YOUR ATTORNEY MAY HOLD YOU LIABLE FOR PAYMENT OF SERVICES. INFORME A SU ABOGADO DE TODO EL PROCEDIMIENTO(S) HECHO CON SSK MD Inc. PARA GARANTIZAR EL PAGO DE LOS SERVICIOS A TRAVÉS DE SU CASO. DE NO INFORMAR A SU ABOGADO LE PUEDE SER RESPONSABLE PARA EL PAGO DE SERVICIOS. * * ***

RE: MEDICAL REPORTS AND DOCTOR'S LIEN (INFORME DE MÉDICO Y GRAVAMEN DE MÉDICO) I hereby authorize SSK MD Inc. (provider) to furnish you, my Attorney, a full report of the examination, diagnosis, treatment, and prognosis in regards to the accident I was involved in on the below date(s) of injury. (Por la presente autorizo SSK MD Inc. (proveedor) entregar a usted, mi abogado, un informe completo del examen, diagnóstico, tratamiento y pronóstico de mí mismo, en cuando estuve envuelto en un accidente en la fecha de la herida escrito por debajo.)

**I hereby authorize and direct you, my Attorney, to pay directly to SSK MD Inc. such sums due and owing for professional services rendered to me, and to withhold such sums from any settlement, judgments or verdicts as may be necessary to adequately protect and fully compensate SSK MD Inc. . I hereby further direct my Attorney to pay in full any medical bills owed to SSK MD Inc.** . (Yo autorizo y le dirigo, mi abogado, para pagar directamente a SSK MD Inc. tales sumas como pueden ser debida y debido por servicios profesionales proveido a mí, y retener tales cantidades de asentamiento, fallos/verdictos o sentencias como sean necesarias para proteger adecuadamente y compensar completamente SSK MD Inc. . Por el presente documento, dirijo mi abogado a pagar en su totalidad cualquier facture(s) médica(s) debido a SSK MD Inc. .)

**I fully understand that I am directly and fully responsible to SSK MD Inc. . for all medical bills submitted by said practice for services rendered and that this agreement is made solely for said practice's additional protection and in consideration of the practice awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. I have been advised that if my attorney does not wish to cooperate in protecting SSK MD Inc. 's interest, the practice will not await payment and may declare the entire balance due and payable.Patient agrees to pay all of SSK MD Inc. 's reasonable attorneys' fees, collection costs and expenses associated with the enforcement of this lien. If SSK MD Inc. is required to retain an attorney to enforce any provision of this Agreement, whether or not a legal proceeding is commenced, the substantially prevailing party shall be entitled to reasonable attorneys' fees regardless of whether at trial, on appeal, in any bankruptcy proceeding, arbitration matter or without resort to suit. In the event SSK MD Inc. is required to turn any outstanding unpaid amounts due under this agreement to a collection agency then Patient agrees to pay any and all costs, fees or charges imposed by said collection agency in collecting amounts due hereunder.** (Entiendo perfectamente que soy directamente y plenamente responsable a SSK MD Inc. todas las facturas médicas presentadas por dicha práctica por los servicios proveidos a mí y que este acuerdo se hace exclusivamente para protección adicional de dicha práctica y teniendo en cuenta la práctica en espera del pago. Y entiendo que dicho pago no es contingente sobre cualquier asentamiento, juicio o veredicto que finalmente puedo recuperar dicha sustantivo. SSK MD Inc. me ha explicado que si mi abogado no quiere cooperar en la protección de intereses de SSK MD Inc. , el proveedor no esperara pago (como lo haríamos con un asunto pendiente) podemos declarar la totalidad del saldo exigible y pagadera, El paciente acepta pagar todos los honorarios razonables de los abogados de SSK MD Inc. , los costos de cobro y los gastos asociados con la aplicación de gravámenes. Si se requiere que SSK MD Inc. conserve a un abogado para hacer cumplir cualquier disposición de este acuerdo, ya sea que se inicie o no un procedimiento legal, la parte que prevalece sustancialmente tendrá derecho a honorarios razonables de abogados, independientemente de si en el juicio, en la apelación, en cualquier procedimiento de quiebra, asunto de arbitraje o sin recurso a juicio. En el caso de que se requiera que SSK MD Inc. dé a una agencia de cobranzas cualquier cantidad pendiente de pago debida en virtud de este acuerdo, el paciente acepta pagar todos y cada uno de los costos, honorarios o cargos impuestos por dicha agencia de cobranzas al cobrar las cantidades adeudadas en virtud del presente acuerdo.)

**I hereby agree to waive the running of any Statute of Limitations for an additional period of four (4) years as provided in CCP 360.5**.Yo estoy de acuerdo de renunciar a la diversión de cualquier estatuto de limitaciones por un período adicional de cuatro (4) años como proporcionar en 360.5 CCP

**The undersigned, being attorney of record for the above patient, does hereby agree to observe all the terms of the above, and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect and fully compensate SSK MD Inc. . Attorney further agrees that in the event this lien is litigated, the prevailing party will be awarded attorney's fees and costs.**

Print First, Middle & All Names: (*Nombre Completo de Paciente*) *BELL, VICTORIA LATOYA*

Date(s) of Injury: (Fecha de Herida) *03/22/2023*

**Driver's Name** (if you were a passenger) (Nombre de Conductor (si fue pasajero) : _____

Patient's Signature *(FIRMA de Paciente)* :

Date *(Fecha)* :

Attorney's Signature *(FIRMA de Abogado)* :

Date *(Fecha)* :

**9121 Atlanta Ave PMB 3399 Huntington Beach, CA 92646, FAX: 888-386-0075**

**eSign liens, submit case updates, bill balance, bill offers, and e-payments at App.RadFlow360.com**

SIERRA COAST
Interventional Pain

555 University Ave, Ste 230
Sacramento, CA 95825

100 N Wiget Ln, Ste 200
Walnut Creek, CA 94598

175 N Jackson Ave. Ste 109
San Jose, CA 95116

3300 Weber St. Ste 601
Oakland, CA 94609

127 Hospital Drive Suite 102
Vallejo, CA 94589

scheduling@sierracoastpain.com
O (916) 264-9757 F (916) 352-6406

Date: 05-23-2025

Patient Name: Victoria Latoya Bell
DOB : 10-25-1983

It is recommended for the patient to obtain an MRI of the left hip.

DX :
Hip
Left Hip Pain [M25.552]

_____
Nima Hosseini, M.D.