LONGWOOD
450 W. SR 434, Ste 1020. Longwood FL 32750
Phone: (321) 207-0200 • Fax: (407)262-0924

KISSIMMEE
506 West Cherry Street. Kissimmee F.L. 34741
Phone: (407) 935-1000 • Fax: (407)935-1001

Today's Date: _____/_____/_____

PATIENT INFORMATION FORM

Pt. Account #: _____

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle: _____

Address: _____ Apt: _____ City: _____ State: _____ Zip: _____

Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____ Work Phone: _____-_____-_____ Marital: S M P D W

Date of Birth: _____/_____/_____ Weight: _____ Age: _____ Sex: M ☐ F ☐ Social Security: _____-_____-_____

Referring Physician: _____ Phone: _____ - _____ - _____

Emergency Contact: _____ Relationship: _____ Phone: _____ - _____ - _____

ACCIDENT INSURANCE COVERAGE

AUTO ACCIDENT? Yes ☐ No ☐ **WORKERS COMP? Yes ☐ No ☐** **SLIP & FALL? Yes ☐ No ☐**

Date of Accident: _____/_____/_____ Do you have an attorney? Yes ☐ No ☐

Attorney Name: _____ Attorney Phone: _____ - _____ - _____

Name of Insurance: _____

Claim Number: _____ Policy Number: _____

Adjuster Name: _____ Adjuster Phone: _____ - _____ - _____ Ext: _____

Did you seek treatment within 14 days of your accident? Yes ☐ No ☐ Where? _____

PRIMARY INSURANCE COVERAGE

Name of Insurance: _____ Effective Date: _____/_____/_____

Insurance ID/Member #: _____ Group #: _____

**If policyholder is other than patient, please complete the following information on the policyholder:*

Policyholder Name: _____ Relationship: _____

Social Security #: _____-_____-_____ Date of Birth: _____/_____/_____ Sex: M ☐ F ☐

SECONDARY INSURANCE COVERAGE

Name of Insurance: _____ Effective Date: _____/_____/_____

Insurance ID/Member #: _____ Group #: _____

**If policyholder is other than patient, please complete the following information on the policyholder:*

Policyholder Name: _____ Relationship: _____

Social Security #: _____-_____-_____ Date of Birth: _____/_____/_____ Sex: M ☐ F ☐

Today's payment will be made by: ☐ Credit/Debit Card ☐ Cash ***We do not accept personal checks***

I authorize release of information to all my insurance companies. I understand that I am responsible for my bill. I authorize use of this form for all my insurance submissions. I authorize ORLANDO DIAGNOSTIC CENTER to release information concerning the procedure to physicians. I authorize my signature to be placed "on file" for purposes of Medicare and insurance claim form submission. Under penalty of perjury, I declare that I have read the forgoing, and the facts alleged are true, to the best of my knowledge and belief.

Patient Signature: _____ Date: _____/_____/_____

Guardian Signature: _____

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ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION

Patient Name: _____
FIRST MIDDLE LAST

Insurance Company: _____

Insurance Member/Claim #: _____

I herby authorize _____ Inc., to furnish the insider's insurance company all information, which said insurance company might request concerning my claim.

ASSIGNMENT OF INSURANCE BENEFITS: The medical benefits otherwise payable to me for their services, but not to exceed the charges of those services. I hereby IRREVOCABLY ASSIGN to ORLANDO DIAGNOSTIC CENTER, INC. any benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and/or charge provided by ORLANDO DIAGNOSTIC CENTER, INC.

I _____ Hereby Authorize _____
Name of Insured Patient Name of Company

Payable directly to: Orlando Diagnostic Center, Inc.

Patients Signature: _____ Date: _____/_____/_____

Witness Signature: _____ Date: _____/_____/_____
Orlando Diagnostic Center Representative

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Florida law requires that your healthcare provider or healthcare facility recognize your rights while you are receiving medical care and that your respect the healthcare providers or healthcare facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your healthcare provider or healthcare facility, a summary of your rights and responsibilities follows:

A patient has the right to be treated with courtesy and respect with appreciation of his individual dignity and with the protection of his need for privacy.

A patient has the right to a prompt a reasonable response to questions and requests.

A patient has the right to know who is providing medical services and who is responsible for his care.

A patient has the right to know what patient support services are available, including whether an interpreter is available if he does not speak English.

A patient has the right to know what rules and regulations apply to his conduct.

A patient has the right to be given healthcare provider information concerning diagnosis, planned course of treatment, alternatives, risks and prognosis.

A patient has the right to refuse treatment, except as otherwise provided by law.

A patient has the right to be given, upon request, full information necessary counseling on the availability of known financial resources for his care.

A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the healthcare provider or healthcare facility accepts the Medicare assignment rate.

A patient has the right to receive a copy of reasonably clear and understandable itemized bill and upon request, to have charges explained.

A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap or source of payment.

A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.

A patient has the right to know if medical treatment is for purposes of experimental research and to give his consent or refusal to participate in such experimental research.

A patient is responsible for providing to his healthcare provider to the best of his knowledge, accurate and complete information
About present complaints, past illnesses, hospitalizations, medications and other matters relating to his health.

A patient is responsible for reporting unexpected changes in his condition to his healthcare provider.

A patient is responsible for reporting to his healthcare provider whether he comprehends a contemplated course of action and what is expected of him.

A patient is responsible for following the treatment plan recommended by his healthcare provider.

A patient is responsible for keeping appointments and, when he is unable to do so for any reason, for notifying the healthcare provider or healthcare facility.

A patient is responsible for his actions if he refuses treatment or does not follow the healthcare provider's instructions.

A patient is responsible for assuring that the financial obligations of his healthcare are fulfilled as promptly as possible.

A patient is responsible for following healthcare facility rules and regulations affecting patient care and conduct.

FILING COMPLAINTS

If you have a complaint about this hospital, please call Administration at (352) 394-4071 ext. 2000. If you have any complaint against a hospital or ambulatory surgical center, call the Consumner Assistance Unit health facility complaint hot line at (888) 419-3456 or write to the address below:

Agency for Healthcare Administration
Consumer Assistance Unit
2727 Mahan Drive
Tallahassee, Florida 32308

If you have a complaint against a physician, call the Medical Quality Assurance, Consumer Services office at (888) 419-3456 or write to the address below:

Healthcare Practitioners
Medical Quality Assurance
Consumer Services
P.O. Box 14000
Tallahassee, Florida 32308

I have received my copy of the Florida Patient Bill of Rights and Responsibilities:

Signature: _____ Date: _____/_____/_____

Witness: _____ Date: _____/_____/_____
Orlando Diagnostic Center Representative