Patient Information Form

Thank you for choosing Hagan Imaging, LLC. Please completely fill out this form to ensure the fastest and best healthcare service. We may ask you to look over this information from time to time to make sure it stays up-to-date.

Patient name	Social Security Number	
Date of Birth	Address	Zip Code
Home phone	Work phone	
Mobile phone or pager	Email address	
Employer	Occupation	

By signing below you are stating that today you are providing us with **ALL OF THE INSURANCE** you are currently covered under and have read and understand the following informational laminated forms provided at time of patient visit including:

1. **STATEMENT OF CURRENT INSURANCE**
2. **STATEMENT OF FEE AND METHOD OF PAYMENT**
3. **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

____

Name of Patient (Print or Type)

____

Signature of Patient

____

Date

____

Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

____

Relationship of Patient Representative to Patient

YOU MUST INFORM US IF YOU HAD AN ULTRASOUND DONE TODAY IN YOUR DOCTORS OFFICE OR AT ANOTHER FACILTY. IF YOU DID, WE MUST RESCHEDULE YOU BECAUSE YOUR INSURANCE WILL NOT PAY FOR OURS. IT WILL BECOME YOUR RESPONSIBILITY FOR THE FULL AMOUNT IF YOU FORGET OR DON'T INFORM US.

THANK YOU

Please be advised that HAGAN IMAGING bills only the technical portion of your ultrasound. You will receive a separate bill from the radiologist who interprets your ultrasound.

Hagan Imaging, LLC
1800 N. Mesa Suite 101
El Paso, Texas 79902
(915) 544-4624 Fax (915) 541-6058

STATEMENT OF FEE AND METHOD OF PAYMENT

This form is utilized to establish a clear understanding regarding the details of your financial account with this practice. Please read it, and do not hesitate to ask any questions. Your signature is an acknowledgment of your understanding and agreement with the provisions of this agreement.

Name of Patient: ________________________ Date: ______________
Name of Responsible Party: _______________ SSN: ______________
Relationship to Patient: ____________________

I, ________________, agree to be responsible for payment in full of the charges for professional services, which have been rendered to the above-mentioned patient by Practice Name. I also understand and agree to the following provisions regarding the fee and method of payment:

1. Practice Name will file primary insurance claims on behalf of the patient for rendered services. Insurance payment shall be made directly to the practice. Should any payment be made to the Responsible Party or any other individual, the Responsible Party agrees to promptly forward payment to the Practice.
2. **The patient or Responsible Party will supply to the Practice any insurance forms that may be necessary to expedite the insurance filing process. Medicare card, monthly Medicaid form or current insurance cards.**
3. The Responsible Party shall pay the co-insurance payment (co-payment) at the time of each service. The co-payment is that part of the fee which is not covered by insurance after the deductible has been paid, or it is the amount that your managed care company (HMO, PPO, etc.) specifies as your personal payment for each appointment.
4. The Responsible Party shall pay any outstanding balance, which is not covered by insurance. The Responsible Party shall also pay claims or any part thereof which are denied or unpaid by an insurance company for any reason, such as for deductible, co-payments, unfiled claims, preexisting conditions, etc. irrespective of who is responsible for the denied claim or the uncovered service. The patient or Responsible Party may receive a statement whenever there is an outstanding balance. The Responsible Party, not the insurance company, is ultimately responsible for payment for the rendered services.
5. If for any reason the account becomes 90 days past due, the Responsible Party or the patient may be billed and expected to bring the account current. Please remember that we file insurance as a courtesy to our patients, and that your insurance contract is between you and your insurance company. We consider payment, therefore, to be the responsibility of the patient if a delay occurs from the insurance company. You will be expected to pay any balance not paid by your

insurance company, or which your insurance company delays beyond 90 days after the date of service.

6. **Hagan Imaging LLC will only bill for the technical portion of services rendered today. This excludes some managed care companies and private pay patients, there will be a separate charge from the radiologist.**
7. Only the business manager is authorized to modify this agreement, or to make any financial arrangements between the practice and the patient. Physicians are specifically excluded from making any financial arrangements with patients.
8. I hereby authorize Practice Name to provide my insurance company with any clinical or financial information, which they may require.
9. Additional details or considerations regarding the method of payment may be outlined below:

____

____

____

Signature of Responsible Party	Date
Signature of Business Manager	Date

Consent to Treatment

I (or my legal guardian or parents) authorize Hagan Imaging LLC to provide medical care reasonable by today's standards.

Signature or Patient/Responsible party: ______________________________

Date: ____________________

Hagan Imaging, LLC

Acknowledgement of Receipt of Notice of Privacy Practices

Hagan Imaging, LLC reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the Notice of Privacy Practices for Hagan Imaging, LLC

____
Name of Patient (Print or Type)

____
Signature of Patient

____
Date

____
Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

____
Relationship of Patient Representative to Patient

Reconocimiento de Recibo de la Notificación de la Privacidad Médica

Hagan Imaging, LLC se reserva el derecho de modificar la privacidad médica indicada en esta notificación.

He recibido una copia de la Notificación de Privacidad Médica de Hagan Imaging, LLC

____
Nombre del (la) Paciente (Impreso ó a Máquina)

____
Firma del (la) Paciente

____
Fecha

____
Firma del Representante del (la) Paciente
(Se requiere si el (la) paciente es menor de edad ó si el adulto no puede firmar esta forma).

____
Relation del (la) Paciente

HAGAN IMAGING

CLIENT ACKNOWLEDGEMENT STATEMENT

"I understand that, in the option of **HAGAN IMAGING**, the services or items that I have requested to be provided to me on____________________2004, may not be covered under the TEXAS MEDICAL ASSISTANCE PROGRAM (Medicaid) as being reasonable and medically necessary for my care. I understand that the HHSC OR its health nursing agent determines the medial necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the service or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care.

TYPE OF SERVICE: ________________________

PRINT NAME: ____________________________

SIGNED NAME: ____________________________

DATE:____________________________________

HAGAN IMANGING

"Comprendo que, segun la opinion de **HAGAN IMAGING**, es possible que Medicaid no cubra los servicios o las provisiones que solicite _______________ 2004, por no considerarlos razonables ni medicamente necesarios para mi salud.Comprendo que el Departamento de Salud de Texas o su agente de seguros de salud determina la necesidad medica de los servicios o de las provisiones que el cliente solicite o reciba. Tambien comprendo que tengo la responsabilidad de pagar los servicios o provisiones que solicite y que reciba si despues se determina que esos servicios y provisiones que solicite y que reciba no son razonables ni medicamente necesarios para mi salud.

Servicios o Productos ______________________________

Nombre del (la) Paciente ____________________________
(Impreso o Maquina)

Firma del (la) Paciente ______________________________

Fecha____

Patient's Name: Medicare # (HICN):

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services.

We expect that Medicare will not pay for the item(s) or service(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, **Medicare probably will not pay for –**

Items or Services:

Because:

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, **you should read this entire notice carefully.**

- Ask us to explain, if you don't understand why Medicare probably won't pay.
- Ask us how much these items or services will cost you (**Estimated Cost: $____________**), in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN & DATE** YOUR CHOICE.

☐ **Option 1. YES. I want to receive these items or services.**

I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items or services and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare's decision.

☐ **Option 2. NO. I have decided not to receive these items or services.**

I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.

Date **Signature of patient or person acting on patient's behalf**

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

OMB Approval No. 0938-0566 Form No. CMS-R-131-G (June 2002)

NOTICE OF PRIVACY PRACTICES FOR

Hagan Imaging, LLC
1800 N. Mesa Suite 101
El Paso, Texas 79902
Mary Hagan, Privacy Officer

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

OUR PRIVACY PROMISE TO YOU, OUR PATIENTS

YOUR INFORMATION IS IMPORTANT AND CONFIDENTIAL. OUR ETHICS AND POLICIES REQUIRE THAT YOUR INFORMATION BE HELD IN STRICT CONFIDENCE.

The terms of this notice apply to all records containing your health information that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

Uses and Disclosures

Treatment-Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment - Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations -Your health information may be used as necessary to support the day-to-day activities and management of Hagan Imaging, LLC. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement -Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting -Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Lawsuits and Similar Proceedings-Our practice may use and disclose your Protected Health Information in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your Protected Health Information in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

Serious Threats to Health or Safety-Our practice may use and disclose your Protected Health Information when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to prevent the threat.

Military- Our practice may disclose your Protected Health Information if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

National Security-Our practice may disclose your Protected Health Information to federal officials for intelligence and national security activities authorized by law. We also may disclose your Protected Health Information to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

Inmates-Our practice may disclose your Protected Health Information to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

Workers' Compensation-Our practice may release your Protected Health Information for workers' compensation and similar programs.

Additional Uses of Information

Appointment reminders-Your health information will be used by our staff to send or call you about appointment reminders.

Information about treatments-Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Other uses and disclosures require your authorization - Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- the right to request restrictions on the use and disclosure of your protected health information. We are not required to agree with your request.
- the right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and copy your protected health information
- the right to amend or submit corrections to your protected health information
- the right to receive an accounting of how and to whom your protected health information has been disclosed
- the right to receive a printed copy of this notice

Hagan Imaging, LLC's Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting Mary Hagan. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints/Contact Person

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Hagan Imaging, LLC
Mary Hagan, Privacy Officer
1800 N. Mesa Suite 101
El Paso, TX 79902
(915) 544-4524

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You may also contact the Ferderal Secretary of Health and Human ServicesYou will not be penalized or otherwise retaliated against for filing a complaint.

This Notice is effective April 14, 2003.