Chart #:___________

REGISTRATION & INSURANCE INFORMATION

Harmindar K. Gill, MD Premier Women's Radiology

NAME:____
Last First Middle Initial

SEX: ☐ Male ☐ Female D.O.B ____/_____/_____ AGE: ________________

SOCIAL SECURITY: _____________________________________ MARITAL STATUS: S M D W

RACE: _______________ Primary Language: ________________ Ethnicity: _________________

ADDRESS: ____

____
City State Zip

HOME PHONE ( ) ________________________ CELL PHONE ( ) ____________________

WORK PHONE: ( ) _______________________ FAX NUMBER: ( ) ____________________

NORTHERN PHONE ( ) ______________________ EMAIL: _______________________________

NORTHERN ADDRESS (if applicable) ____

City__________________________________State__________________________________Zip________

EMERGENCY CONTACT INFORMATION:

NAME: ____

PHONE: ( ) _________________ **RELATIONSHIP:** ________________________

EMERGENCY CONTACT INFORMATION:

NAME: ____

PHONE: ( ) _________________ **RELATIONSHIP:** ________________________

____ _______________________

Patient Signature **Date**

Chart #:___________

PATIENT PRIVACY PREFERENCES

In general, the HIPAA Omnibus privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as electronically in the form or format requested by the individual.

I wish to be contacted in the following manner (Check ALL that apply):
____ Home number ____ Cell number ____ Work number ____ Fax number
____ E-mail ____ Regular mail ____ Do not contact ____ Other

I authorize PWR to release all healthcare information/Radiology Reports of the patient name above to the following:

1. Name: ____

   Address: ____

   City: ______________________ State: ____________ Zip: ________

2. Name: ____

   Address: ____

   City: ______________________State: ____________ Zip: _______

I confirm that all the information provided above on pages 1 & 2 are truthful and accurate to my knowledge. If there were to be any changes to my information I agree to make the staff at PREMIER WOMEN'S RADIOLOGY aware of any changes be to my address, phone number, insurance or medical history.

______________________________________ ____________________
Patient Signature **Date**

Chart #:___________

PATIENT CONSENT and AUTHORIZATION (PLEASE READ CAREFULLY)

RELEASE OF INFORMATION: I consent to sending my medical information to referring physicians, consultants, healthcare providers, hospitals, outpatient facilities, the Social Security Administration, Health Care Financing Administration, its intermediaries, health maintenance organizations, insurance companies, worker's compensation carriers, welfare funds, review companies or organization, and billing agencies. With prior authorization if needed.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign and authorize payment to Premier Women's Radiology/ Dr. Harmindar Gill, herein referred to as "the practice", any and all medical and surgical insurance benefits payable to me the full extent of "the practice's" charge for treatment or services rendered.

GUARANTEE OF PAYMENT: I understand that I am fully and legally responsible for payment of my account. Any agreement made by me with others (i.e. insurance companies, attorneys, etc.) does not involve the physician and does not change my reasonability to pay for services. I agree to guarantee that. Should the amount of benefits be insufficient to cover the expense of treatment, or if the nature of the visit is not covered by said policy, I will be responsible to "the practice" for the payment of the bill at the time of service.

I further agree to pay directly to "the practice" any balance of my account that was intended to be covered by my insurance but, for reasons beyond "the practice's" control, if not paid within sixty (60) days of treatment. Lastly, if any action at law or inequity is brought to enforce this agreement, "the practice" shall be entitled to reasonable attorney's fees, court costs and any other costs of collection required.

____ ____________________

Patient Signature **Date**

FOR MINORS: I hereby grant permission for_______________________________ my minor child

To be treated by Harmindar Gill, MD/Premier Women's Radiology

PAYMENT POLICY

Please read over the following information very carefully before seeing the doctor. This is to eliminate any confusion regarding office policies.

PRIMARY INSURANCE COMPANY: ____________________________ ☐ **HMO** ☐ **PPO**

POLICY HOLDERS NAME_______________________________ D.O.B: ____/_____/______

POLICY ID: __________________________ **GROUP ID**: ________________________

SECONDARY INSURANCE COMPANY: _________________________☐ **HMO** ☐ **PPO**

POLICY ID: __________________________ **GROUP ID:** ________________________

Is this a WORKMANS COMPENSATION CLAIM**?** ☐**YES** ☐**NO** Date of injury: _________

EMPLOYER: _____________________________ OCCUPATION: ______________________

EMPLOYER CONTACT PHONE: (   ) ____

<u>MANAGED CARE PLANS (PPO or HMO)</u>

You are responsible for paying your co-payments at the time of your visit. HMO plans are required to have an authorization number or referral slip from your primary care physician prior to your visit. If this is not obtained prior to your visit, you will be responsible for full payment at the time services are rendered.

If supplemental insurance companies do not pay the 20% portion after Medicare payment within 60 days, you will be responsible for the 20% co-payment.

<u>NO INSURANCE</u>

Unless prior arrangement has been made with our office, FULL PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED. Unless our office is contracted with your private/group health insurance, we do not file the claim for reimbursement. Payment will be due at the time services were rendered.

<u>METHOD OF PAYMENTACCEPTED</u>: CASH, CHECKS, ALL MAJOR CREDIT CARDS.

I HAVE READ THE ABOVE OFFICE POLICY COMPLETELY, I UNDERSTAND & ACCEPT THIS POLICY.

____ ____________________

Patient Signature **Date**

Chart #:___________

REGISTRATION & INSURANCE INFORMATION

Consent for Purpose of Treatment, Payment, or Healthcare Operations

I consent to the use of disclosures of my protected health information by Premier Women's Radiology for the purpose of diagnosing or providing treatment to me, obtaining payment for my health bills or to conduct health care operations. The doctor(s) at P.W.R. may share your health information with the doctor who referred you and to whom you may be referred for additional care.

I understand that diagnosis or treatment of me by Premier Women's Radiology may be conditioned upon my consent as evidenced by my signature on this document.

"Protected health information" means health information, including my demographic information collected from me and collected or received by my physician, another health care provider, a health plan, my employer, or a health care clearing house. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or health care questions. Premier Women's Radiology is not required to agree to the limitations and/or restrictions that I may request. However, if Premier Women's Radiology agrees to a restriction that I request, the restriction is binding on the practice.

I have the right to revoke this consent, in writing, at any time, except to the extent that Premier Women's Radiology has taken action in reliance on this consent.

I understand I have a right to review the Premier Women's Radiology **Notice of Privacy Practices** prior to signing this document.

The **Notice of Privacy Practices** describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or the performance of health care operations.

This **Notice of Privacy Practices** also describes my duties and rights of Premier Women's Radiology with respect to my protected health information.

Premier Women's Radiology reserves the right to change the privacy practices that are described in the **Notice of Privacy Practices**.

I may obtain a revised **Notice of Privacy Practices** by contacting the Office Manager at
27160 Bay Landing Drive, Suite 201, Bonita Springs, Florida 34135.

Name of Patient (please print) ___________________________________Date _______________

Signature of Patient or Representative ____

The patient was asked by me if they have read all pages of the registration packet.

Chart #:___________

Employee Signature ________________________________ Date______________________

PLEASE READ CAREFULLY

PATIENT-DOCTOR ARBITRATION AGREEMENT

This Agreement is made between Harmindar K. Gill, M.D. and her employees, agents, and servants (hereinafter collectively referred to as "Doctor") and ___________________________________ (hereinafter referred to as "Patient"). It is the intention of the parties to this agreement to bind not only themselves but also their heirs, personal representatives, guardians or any persons deriving their claims through or on behalf of the Patient.

It is understood by the Patient that he or she is not required to use the Doctor listed above for radiology, for ambulatory medical facilities or for other radiology or medical services of facilities ("Services"). The Patient also understands that there are numerous other physicians and facilities in this area who are qualified to render quality Services and the Doctor is willing to refer the Patient to another physician or facility in the area for those Services if the Patient requests. Both the Doctor and the Patient agree that arbitration is a preferable method to resolving any disputes they may have in connection with the Services, and wish to avoid the expense and inconvenience of litigation, whether by judge alone or by jury.

It is mutually agreed that any controversy, dispute or claim arising out of or relating to the Services of any kind, including the medical care rendered or payment of medical or surgical fees, or any other matter whatsoever, including the interpretation hereof, shall be settled by arbitration in accordance with the Florida Arbitration Code. The controversy or claim shall be submitted to a single arbitrator (who must be a physician, licensed in Florida) mutually agreed upon by the parties within thirty (30) days of notice of an intent to arbitrate any matter hereunder. If the parties cannot agree upon an arbitrator within such thirty (30) day period a physician, licensed in Florida shall be selected to serve as the arbitrator in accordance with the Florida Arbitration Code through a court which has a situs in Lee County, Florida. The arbitration of such dispute will be held in Lee County, Florida within thirty (30) days after completion of discovery. The award of the arbitrator will be final and binding on all parties to the arbitration and judgment may be entered upon it in accordance with law in any court of competent jurisdiction. In the event of arbitration the parties hereto specifically agree that discovery shall be allowed in the form of written interrogatories, depositions of witnesses, production, inspection and copying of documents to the same extent as is provided under the Florida Rules of Civil Procedure. Provided, however, the time for responding to requests for written interrogatories, production and inspection and copying of documents shall be reduced to ten (10) days. The parties hereto agree to use only American Board of Medical Specialties ("ABMS") board-certified Radiologist as expert medical witnesses, who must agree to adhere to the guidelines and/or code of conduct adopted or recommended by the ABMS for expert witnesses. Any disagreements between the parties to the dispute as to the scope and extent of and compliance with the discovery will be referred to the arbitrator and his or her determination shall be final. The parties further agree that such discovery procedures shall not be extended beyond two (2) months from the selection of the arbitrator; provided, however, that for good cause, the arbitrator shall be permitted in his or her discretion to extend said time for discovery. All expenses of the arbitrator and arbitration (exclusive of each party's attorney's fees, if any) shall be borne equally between the Patient and the Doctor. The parties hereto agree that should any noneconomic damages awarded exceed the limits set forth in Florida Statutes sec. 766.118(2) (generally $500,000.00, with greater amounts allowed under limited exceptions). The definition of noneconomic damages and the calculation thereof shall be consistent with the use of said term and the calculation of noneconomic damages under Florida Statutes (2003) secs. 766.202(8) and 766.118(2). Provided, further, the parties hereto agree that no punitive damages may be awarded. Should any part of the provision of this Agreement be held unenforceable or in conflict with law, the validity of the remaining parts or provisions shall not be affected by such holding.

This Agreement shall remain in effect for all treatment, services and surgery provided to the patient presently and at any future date. I (we) have set our hand(s) this ________day of ___________, _______.
(Month) (Year)

DOCTOR:

By: _________________________
Authorized Agent

PATIENT:

By: ______________________________
Patient (Guardian or Guardian of patient is a minor)