PET/CT SERVICES
OF FLORIDA

Please Write Clearly

Name:
Address:
City: State: ZIP:
SS# Birth Date: Age: Sex:
Phone: Employer:
Spouse's Name: Spouse's Employer:
Primary Care Physician _____ Primary Insurance:
Secondary Insurance:

I request that payment of authorized Medicare, Medicaid, and all other Insurance benefits be made directly to the provider of service Dr. Havas on my behalf. I authorize any holder of medical information about me to be released to my specific insurance carrier if needed to determine benefits for the service(s) performed. I also give my permission to release any previous films or records from any other facility to be released for comparison or treatment purposes.

I hereby authorize the release of all medical records and images to Dr. Havas and P.E.T./CT Services of Florida. I also authorize P.E.T./CT Services of Florida to release my medical records to my other physicians for treatment and/or comparison purposes.
I hereby state that the information given above is correct. If I am under the age of 18, my parent or legal guardian will sign.

A copy of this signature is valid as the original.

X_____**Date X**_____
(Patient/Responsible Party **Signature**)

Person responsible for payment if other than the patient

Name: _____

Address: _____

Affiliation: _____Phone#_____

PET/CT SERVICES
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Informed Consent Agreement

Consent for: **Positron Emission Tomography (PET) Scan**

I hereby authorize PET/CT Services of Florida and/or such associates to perform the above listed procedure.

The nature and purpose of this procedure is to inject a small amount of radioactive glucose or similar tracer into the blood stream. The tracer will be absorbed into the tissue and enable the scanner to produce an image of the tissue. After the injection has had time to be absorbed I will lie on a table as the scanner passes over my body.

There are risks from this procedure. Glucose is a common substance every cell in the body needs to function. Radioactive glucose must pass multiple quality control measures before it is used for any patient injection.

Alternatives to this procedure are Invasive surgery, biopsy, CT scans, MRI, Ultrasound, and X-rays.

I have been informed of the associated risks and alternatives to this procedure.

I also agree to pay any portion of this service that is not paid by my insurance such as co-payment, deductible amount, non-covered, or other charges as allowed.

Date: X_____

Signature: X _____

PET/CT SERVICES
OF FLORIDA

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following individual or organization is authorized to make the disclosure:PET/CT Services of Florida 3404 N Lecanto Hwy. Beverly Hills, Fl 34465 or 1541 SW 1st Ave. Ste 101 Ocala, Fl 34474.
3. The type and amount of information to be used or disclosed is as follows:
   Any CT Scan, X-Ray, P.E.T. Scan, Ultra Sound, MRI and Mammogram reports or films.
4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or humane immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
5. This information may be disclosed to and used by P.E.T./ CT Services of Florida, and my ordering physician and treating physicians unless otherwise specified. I also authorize _____
   To receive information on my behalf.
6. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition_____. If I fail to specify an expiration date, event or condition this authorization will expire in 12 months.
7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy this information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I Have any questions about disclosure of health information , I can contact Office Manager.

Signature of **Patient** or **Legal Representative** **X**_____

If signed by Legal Representative **Relationship** to Patient_____

Date **X**_____

PET/CT SERVICES
OF FLORIDA

3404 N. Lecanto Hwy, Beverly Hills Fl 34465
Phone (352) 746-6888 Fax (352) 746-3335

BENEFICIARY'S CLINICAL COMPLAINT FORM

PET SERVICES OF FLORIDA – BEVERLY HILLS

DATE_____

PATIENT NAME_____

ADDRESS_____

PHONE#_____ALT PH #_____

ACCOUNT #_____DATE OF SERVICE_____

PRIMARY INS_____POLICY #_____

SECONDARY INS_____POLICY #_____

BENEFICIARY'S CLAIM #_____

DATE COMPLAINT RECEIVED_____

EMPLOYEE NAME_____

NATURE OF COMPLAINT_____

_____

_____

INVESTIGATED BY_____ DATE_____

RESOLUTION_____

_____

IF NO INVESTIGATION PERFORMED EXPLAIN WHY_____

_____

DECIDED BY WHOM_____

Patient Acknowledges Receipt of this form (signature **Signature: X** _____

Date: X _____