PATIENT INFORMATION

NAME: ____ SS #: _______________________________

ADDRESS: ____

CITY: _________________________STATE: _________ZIP: _________________________________

PHONE HOME________________________CELL_______________________ WORK___________________

BIRTH DATE:_____________ SEX: MALE / FEMALE HEIGHT:_________WEIGHT:___________

MARITAL STATUS: ____________________________ OCCUPATION:____________________________

PATIENT LIVES WITH: ALONE___ SPOUSE_____ PARENTS ________ OTHER___________

IS THIS INJURY/ILLNESS DUE TO:
A) AUTO ACCIDENT- DATE OF ACCIDENT: ____

B) WORK INJURY- DATE OF INJURY: ____

C) ILLNESS- DATE SYMPTOMS APPEARED: ____

AUTO INSURANCE INFORMATION:
INSURANCE COMPANY: ____

POLICY #:________________________________ CLAIM #:___________________________________

INSURED'S NAME: _______________________________RELATION: __________________________________

ADDRESS:____

CITY: ___________________________________ STATE:______________ ZIP CODE: _____________

PHONE #: _____________________________ ADJUSTORS NAME: ____________________________ EXT:_____

HEALTH INSURANCE INFORMATION:
DO YOU HAVE ANY TYPE OF HEALTH INS? YES or NO (circle one)

INSURANCE CO. NAME: ________________________________ PHONE #: __________________________

ADDRESS: ____

CITY: _____________________________________ STATE:______________ ZIP CODE: _____________

POLICY#: ________________________ GROUP:___________________

INSURED'S NAME:______________________________________DOB___/___/___ RELATION:___________________________

ATTORNEY INFORMATION
ATTORNEY'S NAME: ____

ADDRESS: ____PHONE: _______________________

CITY: ____ STATE:________ ZIP CODE:____________

EMAIL:____

CONSENT FOR TREATMENT

I, the undersigned, a patient in this office hereby, authorize Integra Medical Imaging, (and whomever they may designate as their assistants) to administer treatment as is necessary.

I also certify that no guarantee or assurance has been made to the results that may be obtained.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the release of any medical information necessary to process my insurance claim (s) and also certify that all insurance information given to this clinic is correct and complete.

REQUEST FOR PAYMENT OF BENEFITS TO PROVIDER OF CARE

I hereby authorize ___________________________________insurance Company/Insurance Administrators to pay by check and for it to be mailed directly to Integra Medical Imaging, the expense benefits allowable, and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered, and I have agreed to pay, I n a current manner, any balance of said professional charges. I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill.

ATTORNEY REPRESENTATIONS AND PROTECTION OF BALANCE

I, the undersigned patient am directing my Attorney: ____ to pay outstanding bills out of my settlement and, in effect, protecting any such balance. I fully understand that I am directly responsible for all medical bills and this agreement is made solely for the clinic's additional protection and consideration of their awaiting payment. And 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 the clinic's interest, the clinic will not await payment but will require me to make payment on a current status.

Patient's Signature: ________________________________ Date: ________________

INTEGRA MEDICAL IMAGING
2137 Dixie Highway Louisville KY 40210
Ph 502-414-7788 Fax 859-757-2042

Patient Name____________________________ Patient Weight_____________ pounds

Symptoms(Left/Right side)____

Please indicate the correct answer as it pertains to you by circling YES or NO.

1.	BRAIN CLIPS (CEREBRAL ANEURYSM SURGERY)	YES	NO
2.	CARDIAC PACEMAKER	YES	NO
3.	PREGNANCY	YES	NO
4.	COCHLEAR IMPLANTS (EAR SURGERY)	YES	NO
5.	CLAUSTROPHOBIA (FEAR OF CLOSED PLACES)	YES	NO
6.	METAL FRAGMENTS OR SHAVINGS IN HEAD, EYES OR SKIN (JOB RELATED EXAMPLE METAL WORKER)	YES	NO
7.	AORTIC CLIPS (HEART SURGERY)	YES	NO
8.	ARTIFICIAL HEART VALVES	YES	NO
9.	BONES WITH RODS, PINS, PLATES OR SCREWS	YES	NO
10.	HARRIGHNTON RODS	YES	NO
11.	INSULIN PUMP	YES	NO
12.	INTRAUTERINE CONTRACEPTIVE DEVICE (IUD)	YES	NO
13.	PENILE IMPLANT	YES	NO
14.	JOINT REPLACEMENT OR ARTIFICIAL LIMB	YES	NO
15.	NEUROSTIM (TENS UNIT) INTERNAL/EXTERNAL	YES	NO
16.	SHRAPNELL, GUNSHOT OR PELLET WOUND	YES	NO
17.	SHUNT (SPINAL OR VENTRICAL)	YES	NO
18.	WIRE SUTTURES OR METAL SURGICAL CLIPS	YES	NO
19.	DENTURES	YES	NO
20.	HEARING AIDS	YES	NO

List any previous Diagnostic Test that applies to the Exam you are having today. (Example: CT Scan, Ultrasound, Bone Scan, and Prior MRI)

____

____

List all previous surgeries with dates:

____

____

For your safety and to obtain the best exam possible, please remove all jewelry, watches, keys, credit cards, glasses, hairpins, and dentures. You may be required to change clothes depending on which exam you are having.

I have read all of the above and have been given the opportunity to ask questions concerning this exam.

Patient Signature: _______________________________ Date: ___________________

Technologist Signature: _____________________________ Date: ___________________

ASSIGNMENT, LEIN, AND AUTHORIZATION

FOR DIRECT PAYMENTS BY MY PAYERS S & J Pharma Consulting LLC, dba INTEGRA MEDICAL IMAGING

("Assignment & Lien")

Purpose. The purpose of this Assignment & Lien is to assist the Office in collecting from various Payers who may be responsible for paying on my Charges. Accordingly, I agree to the following and direct all Payers as follows:

Definitions. In this Assignment & Lien, the following terms shall have the following meaning: "Office" and "Clinic" shall refer to S & J Pharma Consulting LLC dba Integra Medical Imaging.; located at 335 Broadway Street, Paintsville, Ky 41240 "Payer" shall refer to without limit any insurance carrier, health benefit plan administrator and fiduciary, health maintenance organization, preferred and independent provider organization, attorney, at-fault party, individual, and any other entity, which may elect or be obligated to pay or disburse Proceeds, wither now or in the future; "Proceeds" shall include without limit the proceeds from any entity, which may elect or be obligated to pay or disburse Proceeds, either now or in the future; "Proceeds" shall include without limit the proceeds from any settlement, judgment, or verdict, the proceeds from any promise to pay or reimburse, the proceeds relating to "health-care-insurance receivables" and/or "payment intangibles" as such are defined by the applicable Uniform Commercial Code, and the proceeds relating to the following benefits, plans, or coverages: individual and group health benefits, Medicare, Medicaid, workers' compensation, disability, liability, uninsured and underinsured motorist, no-fault, medical payments benefits, personal injury protection, lost wages, lost services, property damage, errors & omissions, and malpractice, "Charges" shall include without limit the full fees for the Office's services (including without limit treatment, diagnostic services, medical equipment, supplies, supplements, narrative reports, photocopies, depositions, and testimony, whether rendered before or after the date of this Assignment & Lien), any Collection Costs incurred by the Office, delinquency penalties and interest to the maximum extent permitted under law or at the annual rate of eighteen percent (18%), whichever is greater, and any other charges incurred by me at the Office; : "Collection Costs" shall include without limit any pre- and post judgment court costs, filing fees, service of process charges, attorneys fees, fees or costs associated with requests for reconsideration, independent reviews, appeals, mediation, arbitration, and any other costs of collection incurred by the Office in any effort or action to collect my Charges either from me or from any Payer.

Assignment and Lien Terms, I hereby assign to the Office to the extent permitted by law, but only to the extent of my Charges, all of my rights, remedies, and benefits relating to any Payer, including without limit a primary, non-contingent right to receive Proceeds from any Payer now or in the future, and any and all causes of action that I might have against and payer now or in the future, the right to prosecute such causes of action either in my name or in the Office's name, and the right to settle or otherwise resolve such causes of action as the Office sees fit. I agree that this assignment shall be effective as of the date and time my condition first arose. I further intend for this Assignment & Lien to create a secured interest under the applicable Uniform Commercial Code. Accordingly, I hereby grant to the Office a primary, non-primary, non-contingent secured interest in all Proceeds to the extent permitted by law for the purpose of securing payment of my Charges, which secured interest shall attach and also be automatically perfected effective as of the date and time that my condition first arose. I further authorized the Office to file the from(s) normally filed with the secretary of state or other governmental agency relating to such secured interests, and to make such filings in all relevant jurisdictions as the Office sees fit in its sole discretion. I agree that once payment in-full has been made towards all outstanding Charges to the full extent permitted by law or contract and also as defined by my agreement with the Office, such secured interest shall be removed or terminated solely upon my written request sent through the U.S Postal Service Certified Mail. Consistent with these terms, I hereby direct any and all Payers, to pay the Proceeds directly to, immediately to, and exclusively in the name of the Office to the full extent of my Charges. To the extent that any law, including without limit a lien statue, purports to limit through the reservation of a portion of the Proceeds exclusively to me, I hereby waive such limits, reductions, or modifications. Such waiver shall not adversely affect or prejudice any rights which the Office may have and elect to exercise under said law.

Specific Direction to Any Attorney I Retain, Such as in Accident Cases. In the event that I retain one or more attorneys to assist me in the collecting any Proceeds, I hereby direct (and the Office hereby requests) each attorney to provide immediate notice to the Office regarding any Proceeds received by the attorney, to promptly pay the Office in-full out of such Proceeds, and to provide a full accounting of such Proceeds to the Office. I agree that the purpose of any Proceeds received by the attorney shall be primarily to pay my Charges. If I have a dispute regarding the Charges, any remedies I may have shall not include instructing my attorney to withhold or delay payment of Proceeds to the Office. I further agree to and hereby irrevocably waive any present or future right I may have, whether arising under a "Common Fund Doctrine" or other legal basis, to require the Office to reduce its Charges or balance by a proportionate or weighted share of my attorney's fees , costs and other expenses of pursuing collection of my claims, including the Office's Charges.

Disclosure Directives. I hereby direct each and every Payer to immediately release to the Office any Pertinent Information relating to (a) any coverage I may have (b) any Determination by the Payer relating to the Office's Charges. "Pertinent Information" shall include without limit the amount of total coverage available and remaining, as well as the amount of any outstanding claims which the Payer has received from any claimant relating to my condition. "Pertinent Information" shall also include without limit copies of all documents, records, and other information (a) relied upon by the Payer in making a Proceeds Determination, or (b) was submitted, considered, or generated in the course of making a Proceeds Determination without regard to whether such document, record, or other information was relied upon in making the Proceeds Determination. "Proceeds Determination" shall include without limit any determination by the Payer to pay, deny, or delay payment of any Proceeds relating to the Office's Charges, as well as a decision to refer the Charges to an independent review or audit, utilization review, or independent medical exam. I further authorize and direct the Office to release any information relating any services rendered to or for me by the Office to all Payers, including without limit a copy of my Charges and a copy of the Assignment & Lien.

Miscellaneous. Except as provided in this paragraph, this Assignment & Lien shall not be modified or revoked without the expressed, written consent of the Office. I hereby revoke, with the Office's consent, the terms of any previously signed documents, but only to the extent those terms conflict with the terms of this Assignment & Lien I agree that each and every provision of this Assignment & Lien is reasonable necessary for the protection of the rights and interests of the Office and myself. However, should any provision of this Assignment & Lien be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Assignment & Lien shall, nevertheless, remain in full force and effect. This Assignment & Lien shall be governed under the laws of the state where the Office is located, and is performable in the county where the Office is located. In any action based upon this Assignment & Lien, I hereby consent to personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum inconvenience. I further waive any statute of limitations which may apply in any action based upon this Assignment & Lien.

I have read, understood, and agree to the terms of this Assignment & Lien.

Patient Name (print):_____________________________________ Patient Signature:___________________________________ Date:__/__/__

Legal Guardian (print):___________________________________ Guardian Signature:_________________________________ Date:__/__/__

Attorney Name (Print)_____________________________________Attorney Signature__________________________________ Date:__/__/__

LIMITED POWER OF ATTORNEY and MEDICAL RELEASE

POWER OF ATTORNEY TO ENDORSE CHECKS AND/OR TO SIGN ANY PAPER WHICH WILL ENHANCE OR EXPEDITE PAYMENT TO PROVIDER FOR SERVICES RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS/AUTHORIZATION TO PAY.

Know by all these present that: The undersigned has made, constituted and appointed, and by these presents does hereby make, constitute and appoint INTEGRA MEDICAL IMAGING and any of it's duly authorized agents and employees as and to be the undersigned's true and lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and INTEGRA MEDICAL IMAGING which checks, knowledge and approval of the undersigned and/or the maker of the check, draft or money order.

Furthermore, the undersigned allows INTEGRA MEDICAL IMAGING or any of its agents to sign any paper that will be necessary to enhance, expedite and/or allow payment to the said provider. This may include affidavits of non-ownership of vehicles, insurance forms and other statements.

The undersigned by these presents does give and grant INTEGRA MEDICAL IMAGING as attorney the full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and cashing of said checks are concerned as well as any other document.

MEDICAL RELEASE

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services or supplies pertaining to me to release true copies of same to INTEGRA MEDICAL IMAGING or any insurer providing coverage to me in connection with the processing of any claim for benefits made by me or by the assignee herein.

A photocopy of this document shall be as binding as an original signature page.

The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do or cause to be done by virtue of these presents.

RELEASE OF INFORMATION: I hereby authorize this medical provider to: furnish my insurance company or companies and the patient's attorney with any and all information that may be contained in my medical records; to obtain coverage telephonically from my insurer; to request a written non-redacted PIP payout sheet from the insurer; and to obtain copies of my medical records, including but not limited to, documents, reports, scans, notes, opinions, x-rays, and MRI's received from any other medical provider or any insurance company. The insurer is directed to keep the patient's medical records private and confidential. The insurer is NOT authorized to provide these medical records to anyone, including but not limited to, third party vendors without the patient's and provider's prior written permission. If the insurer schedules a defense examination or examination under oath (hereinafter "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to this provider. The provider or the provider's attorney is expressly authorized to appear at any EUO or IME set by the insurer and a copy of those statements may be obtained by my provider upon request of that information. The health care provider is not the agent of the insurer or the patient for any purpose.

____/____/____
PATIENT’S SIGNATURE PATIENT’S NAME-(PLEASE PRINT)
DATE

____/_____/____
ATTORNEY’S SIGNATURE ATTORNEY’S NAME (PLEASE PRINT)
DATE