CONCIERGE DIAGNOSTICS, INC - PATIENT INFORMATION

Please provide the following information. Thank you.

NAME: ____ DATE OF BIRTH:_____________________ SEX: M F

ADDRESS: ____

STATE: ____ ZIP CODE: _________________________________

HOME PHONE _______________________________________ CELL: _____________________________________

EMAIL: ____

RACE:
Please check one ___ American Indian or Alaskan Native ___ Black or African American
___ Native Hawaiian or other Pacific Islander ___Asian ___ White/Caucasian ___ Patient Declined

ETHNICITY:
Please check one ___ Latino or Hispanic ___ Not Hispanic or Latino ___ Patient Declined

MARITAL STATUS: ___ Never Married ___Married ___Annulled ___Widowed ___Separated ___Divorced

EMPLOYEMENT STATUS: ___Employed ___Unemployed ___Full-Time Student ___Part time Student ____ Retired

SOCIAL HISTORY: How often do you smoke?
___ Never ___________Former/Date Quite ___Current Smoker _________ Packs/Day

How often do you drink alcohol?
___ Socially ___Weekly ___Daily ___Beer/Wine _____Liquor ____ Never

PRIMARY INSURANCE: ____

SECONDARY INSURANCE: ____

PRIMARY CARE PHYSICIAN: ____

PREFERRED LABORATORY: ___Quest ___LabCorp ____Other: ______________________________

ARE YOU PREGNANT?..YES NO DUE DATE: ______________
DO YOU HAVE A PACEMAKER?..YES NO SINCE WHEN: ____________
DO YOU HAVE ANY METAL IMPLANTS?...............................YES NO WHERE: _________________
HAVE YOU EVER BEEN DIAGNOSED WITH CANCER?.........YES NO WHEN: __________________
HAVE YOU HAD HEARING TEST RECENTLY?.......................YES NO DATE: ___________________
HAVE YOU HAD A VISION TEST RECENTLY?........................YES NO DATE: ___________________
ARE YOU DIABETIC?..YES NO LAST A1C TEST: __________
HAVE YOU HAD BLOOD WORK IN THE LAST 3 MONTHS?..YES NO WHEN: __________________

CONCIERGE DIAGNOSTICS, INC.
601 Brickell Key Drive, Suite 700, Miami, FL 33131
Phone: (305) 714 – 2160
Fax: (305) 397 – 1156

HIPPA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT & AUTHORIZATION

The Health Insurance Portability and Accountability Act of 1996 (HIPPA) requires us to provide you with our Notice of Privacy Practices which explains our privacy practices and how we may legally use and disclose your Protected Health Information (PHI). In order to protect your privacy and confidentiality, we ask that you authorize when, and to whom, protected health information can be released.

May we leave detailed message on your home or cell phone answering machine? ___YES ___NO

May we phone you at work and leave a message to call our office back? ___ YES ___NO

Do we have your permission to talk to family members or other individuals? ___ YES ___NO

If yes, please provide the names, phone numbers and relation to you:

Name: ________________________________ Phone: ____________________ Relation: ________________

Name: ________________________________ Phone: ____________________ Relation: ________________

Name: ________________________________ Phone: ____________________ Relation: ________________

By signing this form, I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them. I have been given the opportunity to ask question, and I understand the Notice of Privacy Practices, I understand that this form will be placed in my patient chart and maintained for six years.

Print Patient Name: ____

Patient Signature: ____ Date: ________________

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RECORD RELEASE AUTHORIZATION

Doctor / Hospital: ____

Address: ______________________________ City: ______________ State: _____ Zip: ________

I hereby authorize and request the release of my medical records to:

CONCIERGE DIAGNOSTICS, INC.
601 Brickell Key Drive, Suite 700, Miami, FL 33131
Phone: (305) 714 – 2160 Fax: (305) 397 – 1156

Thank you in advance for your cooperation.

Patient Name: _______________________________________ Date of Birth: ________________

Patient Signature: ____

Relationship / Authority if not signed by patient: ____________MANAGER / STAFF MEMBER________

Witness Signature: ______________________________________ Date: ___________________

I acknowledge that it may be necessary to compare studies with other test results from other medical facilities, physicians, lab, etc. and authorize the release of any pertinent medical information to Concierge Diagnostics, Inc.

PLEASE SEND: LAST 3 OFFICE NOTES, MEDICATION LIST, LAB WORK AND DIAGNOSTIC TEST RESULTS IF APPLICABLE.

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INFORMED CONSENT FOR DIAGNOSTIC ULTRASOUND EXAMINATION AND CO-PAYMENT RESPONSIBILITIES

Your physician has requested that we perform an ultrasound/sonogram (US) to obtain additional information. This is a diagnostic test that uses sound waves and a computer to produce images of internal body parts. The benefit of this exam is to assist your physician with making a diagnosis. There may be other imaging alternatives, however, your physician believes that a sonogram to be the best diagnostic test for you after evaluating your symptoms and medical condition at this time.

By my signature below, I hereby certify that I have fully read this consent, had it explained to me or have had it read to. I have been given an opportunity to ask questions about my condition, alternative forms of treatment, the procedures to be used, and the risks and hazards involved. I understand its contents and have sufficient information to give this informed consent.

Female Patients: By my signature on this form, I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected of confirmed at this time. If you are pregnant or think that you may be, please notify the front desk or the sonographer conducting your ultrasound.

Patient Name: ____ Date: _________________________

Signature: ____

CO-PAY AND OUT-OF-POCKET POLICY: I acknowledge that Concierge Diagnostics may impose a standard visit co-pay for in-office services and for in-home services, irrespective of any contractual agreements with insurance providers. I understand that this fee is entirely distinct from any deductibles or co-insurance amounts set forth by my insurance company. I further understand that this co-pay is not contingent upon insurance coverage and applies uniformly to insured and uninsured patients as part of Concierge Diagnostics' medical service fee. I hereby agree not to seek reimbursement for this co-pay or any out-of-pocket expenses once I have received services from Concierge Diagnostics. I confirm that I have been provided with a comprehensive explanation of these terms, and my signature serves as evidence of my understanding and acceptance thereof.

Patient Name: ____ Date: _____________________________

Signature: ____

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Power of Attorney and Medical Release

POWER OF ATTORNEY TO ENDORSE CHECKS AND/OR TO SIGN ANY PIECE OF PAPER WHICH WILL ENHANCE OR EXPEDITE PAYMENT TO PROVIDER FOR DIAGNOSTIC SERVICE RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS AND ASSIGNMENTS 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 Concierge Diagnostics, Inc. and any of its duly authorized agents and employees as and to be undersigned's true and lawful attorney for and in undersigned's name, place and stead to endorse all checks, drafts or money orders which are made payable to the undersigned alone or the undersigned and the said Concierge Diagnostics, Inc, at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft or money order.

Furthermore, the undersigned allows Concierge Diagnostics, Inc., or any of its agents to sign any paper that will be necessary to enhance, expedite and/or allow payment to 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 THE SAID *QUALIS DIAGNOSTICS, LLC DBA CONCIERGE DIAGNOSTICS, INC.* 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 PURPOSED 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, diagnostic services, or supplies pertaining to me to release true copies of same to Concierge Diagnostics, Inc 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 a binding as an original signature page. The undersigned does hereby ratify and confirm any and all actions taken by 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.

ASSIGNMENT OF BENEFITS

I ____, hereby authorize my health insurance plan to make medical benefits payments otherwise payable to me for services rendered at Qualis Diagnostics, LLC. dba Concierge Diagnostics, Inc. but not to exceed the charges of those services, payable and mailed directly to:

Qualis Diagnostics, LLC. dba Concierge Diagnostics, Inc. located at: 601 Brickell Key Drive, Suite 700, Miami, FL 33131

Furthermore, I hereby IRREVOCABLE ASSIGN Qualis Diagnostics, LLC. dba Concierge Diagnostics, Inc. the rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statuses for any service or charges provided by Concierge Diagnostics, Inc.

IN WITNESS WHEREOF the undersigned have hereunto set their hands, this ________ /____________ / _____________
Month Day Year

Patient Signature: ____