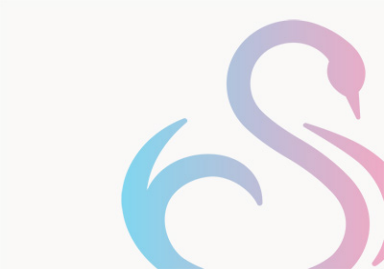


SERENE DIAGNOSTIC IMAGING
1751 David Walker Dr
Tavares, Fl 32778
(352) 800-6500—PHONE
(352) 800-6501—FAX

PATIENT APPROVAL FOR SERVICES RENDERED

I hereby authorize this facility to perform medical services and to bill my insurance company for services rendered at the above facility. The facility will send the claim to the listed insurance company(ies) as a courtesy. I am responsible for knowing the parameters of my insurance, and once processed by the listed insurance company I am liable for payment of the balance due. I also understand that any fees collected up front are estimates based on information obtained from my insurance prior to testing.

I also understand that if my insurance is billed and the procedure is denied for any reason, including but not limited to; lack of medical necessity and/or procedure performed too soon; I will be held responsible for full payment as designated by Serene Diagnostic Imaging Corp.

I request that payment of authorized benefits be made on my behalf to the above provider for services furnished. I authorize release to the indicated insurance carrier any medical information needed to determine these payments for related services.

I understand that a copy of images may be requested to be reviewed by the ordering physician or other physician I will see in the future. I also understand that a copy of the report must be obtained from the ordering physician rather than the imaging facility. The first disc will be provided as a courtesy, any additional request will incur a fee of $10.00 per disc.

I also understand that it is my responsibility to pay for any fees resulting from the account being sent to a collection agency.

I understand that this document covers all services rendered within a year of my signature.

PATIENT INFORMATION

Patient Name Printed: _____

DOB: _____ **Patient Phone Number:** _____

Patient Mailing Address: _____

Patient Email Address: _____

Date_____ **Patient Signature** _____

Date_____ **Witness Signature** _____

If Patient is a Minor, name of Guarantor: _____

Patient Authorization to Release Medical Information

Patient : _____ D.O.B._____SS#: _____

I hereby authorize_____ to release any medical information to *Serene Diagnostic Imaging* pertaining to myself:

_____
Print Name

Specific Information Requested:

_____

I hereby authorize Serene Diagnostic Imaging Corp to release any medical information pertaining to myself to:

_____

_____
Patient Signature

_____
Witness

_____
Date

Serene
Diagnostic Imaging
1751 David Walker Drive - Tavares, FL 32778 | Phone: (352) 800-6500 | Fax: (352) 800-6501

Serene
Diagnostic Imaging

MAMMOGRAM WORKSHEET

Name: Date:

DOB / Age: Physician:

Any previous mammogram : yes☐ no☐

Where? _____ When? _____

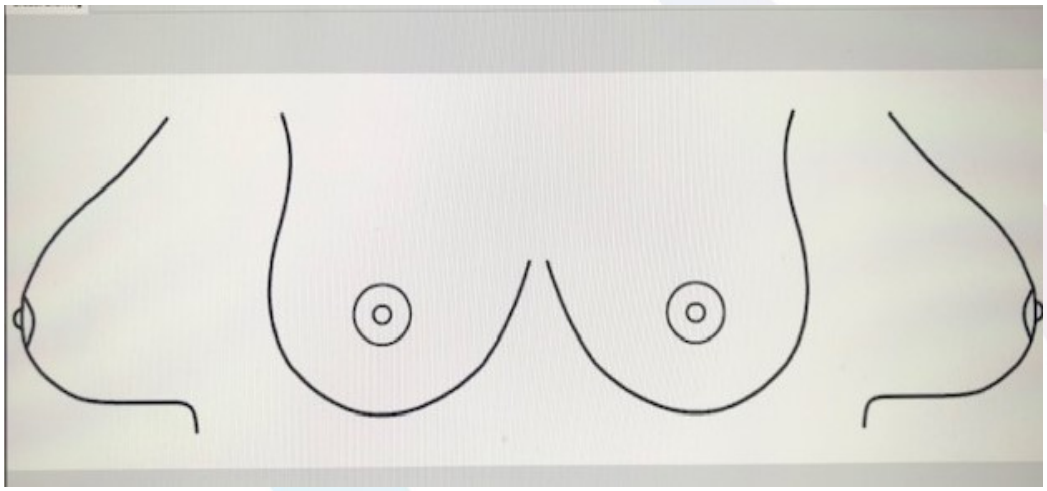
Any current symptoms (pain, lump, discharge, thickening): _____

Since when? _____ Implants / reconstruction: _____

Any breast cancer in your family, relationship? _____

Previous surgery: lumpectomy ☐ mastectomy ☐ biopsy ☐ when? _____

Which breast?



Comments (lump location, palpable? Scar, retraction, pain):

Tech.initials:

Serene Diagnostic Imaging

1751 David Walker Drive Tavares, FL 32778 Tel: (352) 800-6500 Fax: (352) 800-6501

Acknowledgement of Receipt of Notice

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

Signed:_____ Date:_____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

- ☐ parent or guardian of minor patient
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient

Name of Patient: _____

For Office Use Only:

☐ Signed form received by: _____

☐ Acknowledgment refused:

Efforts to obtain:

_____

_____

Reasons for refusal:

_____

_____

DEXA Scan Questionnaire

MR#

Name: Date of Birth:

Ethnicity: Height: Weight:

Date of Last DEXA:

Personal History

	YES	NO
Are you a smoker?		
If yes, on average how many cigarettes a day?		
Alcohol?		
If yes, on average how many drinks a day?		
Height Loss since High School?		
If yes, how many inches?		
Family History of Osteoporosis?		
Personal History of Osteoporosis?		

	YES	NO
Exercise?		
If yes, how often?		
Fractures?		
Hip		
Spine		
Wrist		
Any fracture after the age of 50?		

Medical History

	YES	NO
Have you had a hysterectomy?		
If yes, partial or total and at what age?		
Hormone Replacement?		
If yes, how long?		
Hyperthyroidism		
(Overactive Thyroid or Grave's Disease)		
Hyperparathyroidism		
(Overactive Parathyroid, excessive PTH Secretion, High calcium)		

MEDICATION	YES	NO	How long?
Steroids			
Boniva			
Fosamax			
Miacalcin/Calcitonin			
Actonel			
Calcium			
Seizure Medication			
Evista			
Forteo			

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