Acknowledgement of Receipt of Notice

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. A copy is available at front desk.

Patient Name Printed: ______________________________________ Today's Date: ______________________

Signature: ____ 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:

____

____

Serene Diagnostic Imaging

Patient Authorization to Release Medical Information

Patient Name: ______________________________ Date of Birth: __________________

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:

____

PLEASE SEND REQUESTED MEDICAL RECORDS TO:
SERENE DIAGNOSTIC IMAGING
1751 DAVID WALKER DR
TAVARES, FL 32778
PHONE: 352-800-6500
FAX: 352-800-6501

____
Patient Signature

____
Witness

____
Today's Date

CONFIDENTIAL

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

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 medical report can be obtained after it was received by the ordering physician. The first disc will be provided as a courtesy, any additional request will incur a fee of $15.00 per disc. I understand for mammograms a lay report will be sent to the email address provided below. If there is no email provided the lay report will be sent regular mail.

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 EMAIL ADDRESS: ____

Patient Mailing Address: ____

City: __________________________ State: ______________ Zip Code: ____________________

Patient Signature: _____________________________________ Date: _____________________

If Patient is a Minor, name of Guarantor: ____

Serene
Diagnostic Imaging

MAMMOGRAM WORKSHEET

Name: Today's Date:

Date of Birth: Referring Physician:

Any previous mammogram? Yes____ No____

Date of previous mammogram: ____________________ (month, year)

Location of previous mammogram: _______________________________ (name, city)

Any current symptoms? (pain, lump, discharge, thickening etc): __________________

Since when? ____

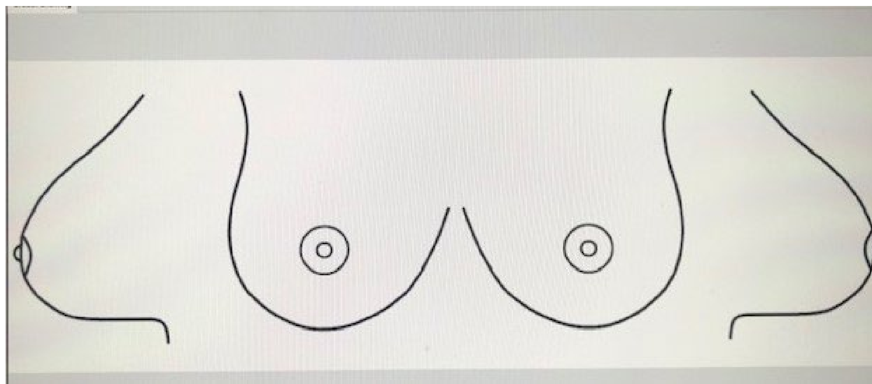
Any breast cancer in your family? ________ Relationship: _______________________

Any previous breast surgeries? Yes____ No____

Lumpectomy____ Mastectomy____ Biopsy____ Implants____ Reconstruction____

When? ___________________ Which breast? Right____ Left____

TECHNICIAN NOTES ONLY



Tech Initials:

DEXA Scan Questionnaire

SDI#

Name: Date of Birth:

Ethnicity: Height: Weight:

Date of last Bone Density Scan:

Personal History

Are you a smoker? YES NO

If yes, how many cigarettes a day? ________________________

Alcohol? (3 or more units per day) YES NO

Height loss since high school? YES NO

If yes, how many inches? __________________________________

Family history of osteoporosis? (Parent hip fracture) YES NO

Personal history of osteoporosis? YES NO

Exercise? YES NO

If yes, how often? _______________________________________

Fractures?

Hip YES NO

Spine YES NO

Wrist YES NO

Any surgeries in the hip or back? YES NO

Any fractures after the age of 50? YES NO

Medical History

Have you had a hysterectomy? YES NO

If yes, partial or total and at what age? ____________________

Hormone Replacement? YES NO

If yes, how long? ____

Hyperthyroidism YES NO

(Overactive Thyroid or Grave's Disease)

Hyperparathyroidism YES NO

(Overactive Parathyroid, Excessive PTH Secretion, High Calcium)

Medications	YES	NO	How long?
STEROIDS			
BONIVA			
FOSAMAX			
MIACALCIN/CALCITONIN			
ACTONEL			
CALCIUM			
SEIZURE MEDICATION			
EVISTA			
FORTEO			

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