Film/CD Release Form

Date: _____ Patient Account Number:_____

I,_____, acknowledge that upon leaving the facility I may be given or request a copy of my images. I understand that I am responsible for this copy of my images, which may include delivering my images to my physician if requested. Initial copies of images are free.

For any reason, if additional copies are requested by me, they will be subject to the following charges:

$1.50 charge per CD

$3.50 per sheet of film (most studies require multiple film sheets)

Name of Patient (Please Print): _____

Signature of Patient and/or Guardian: _____

Type of Study Release:

MRI _____	DATE OF STUDY: _____	CD or FILM
MRI _____	DATE OF STUDY: _____	CD or FILM
CT _____	DATE OF STUDY: _____	CD or FILM
CT _____	DATE OF STUDY: _____	CD or FILM
XR _____	DATE OF STUDY: _____	CD or FILM
XR _____	DATE OF STUDY: _____	CD or FILM
US _____	DATE OF STUDY: _____	CD or FILM
US _____	DATE OF STUDY: _____	CD or FILM

Revised 11/21/2023

Patient Authorization

Name: _____

Address: _____

Date of Birth: _____ Social Security Number: _____

Home Phone Number: _____ Cell Phone Number: _____

Email: _____

In Case of Emergency, contact: _____

(Name) (Phone Number)

I grant permission to *ImageCare LLC* to communicate and release my health/billing information to the following people:

Name: ***Relationship:***

_____

_____

Do you have an Advance Directive or Living Will? **Yes** **No** *(If you need information, we can provide it)*

X-RAY/FILM RECORD RELEASE

I hereby authorize the release of my films and/or x-rays and related reports/records for the purpose of my condition or suspected condition as requested by the referring physician, specialist or other to: ***ImageCare***

Patient or Guardian Signature: _____ Date: _____

I hereby authorize ImageCare Centers to release all medical records and/or films to any medical practitioner, insurance company/agent, attorney, etc. for the purpose of treatment or for the purposes related to the payment of the services rendered. On consideration of services rendered, I hereby irrevocably assign and transfer to ImageCare Centers all rights, title, and interest in the benefits payable for the services rendered by ImageCare Centers provided in the above-mentioned policy(ies) of insurance. I will pay ImageCare Centers for all charges incurred or alternately for all charges in excess of the sums actually paid or denied pursuant to said policy(ies). If ImageCare Centers is unable to collect payment for services rendered herein and must use collection agency, I will be responsible for all collection and/or attorney's fee incurred, in addition to interest accruing from the date of service. A Photostat copy of this authorization shall be considered as effective and valid as the original. I hereby acknowledge that I will not file suit and/or arbitration for the payment of the above provider's medical bills unless I am requested to do so by the medical provider.

Patient or Guardian Signature: _____ Date: _____

PATIENT BILL OF RIGHTS

Each patient receiving services in our facility shall have the following rights:

1. To be informed of these rights, as evidenced by the patient's written acknowledgement, or by documentation by staff in the medical record, that the patient was offered a written copy of these rights and given a written or verbal explanation of these rights, in terms the patient could understand. The facility shall have a means to notify patients of any rules and regulations it has adopted governing patient conduct in the facility.
2. To be informed of services available in the facility names and professional status of personnel providing patient's care, and of fees and related charges, including payment fee, deposit and refund policy of the facility and any charges for services not covered by sources of third-party payment or not covered by the facility's basic rate.
3. To be informed if the facility has authorized other health care and educational institution to participate in the patient's treatment. The patient also shall have a right to know the identity and function of these institutions and to refuse to allow their participation in the patient's treatment.
4. To receive from the patient's physician(s) or clinical practitioner(s), in terms that the patient understands, an explanation of his/her complete medical health condition or diagnosis, recommended treatment, treatment option, including the option of no treatment, risk(s) of treatment, and expected result(s). If this information would be detrimental to the patient's health or if the patient is not capable of understanding the information, the explanation shall be provided to the patient's next of kin or guardian, along with the reason for not informing the patient directly, shall be documented in the patient's medical record.
5. To participate in the planning of the patient's care and treatment, and to refuse medication and treatment. Such refusal shall be documented in the patient's medical record.
6. To be included in experimental research only when the patient gives informed, written consent to such participation, or when a guardian gives such consent for an incompetent patient in accordance with law rule and regulation. The patient may refuse to participate in experimental research, including the investigation of new drugs and medical devices.
7. To voice grievances or recommend changes in policies and services to facility personnel, the governing authority and/or outside representatives of the patient's choice either individually or as a group and free from restraint, interference, coercion, discrimination, or reprisal.
8. To be free from mental and physical abuse, free from exploitation and free from use of restraints unless they are authorized by the physician for a limited period of time to protect the patient or others from injury. Drugs or other medications shall not be used for discipline of patients or for convenience of facility personnel.
9. To confidential treatment of information about the patient. Information in the patient's medical record shall not be released to anyone outside the facility without the patient's approval, unless another healthcare facility to which the patient was transferred required the information, or unless the release of the information is required and permitted by law, a third-party payment contract, a peer review or unless the information is needed by the NJ State Department of Health for statutory authorized purposes. The facility may release data about the patient for studies containing aggregated statistics when the patient's identity is masked.
10. To be treated with courtesy, consideration, respect and recognition of the patient's dignity, individuality, and the right to privacy, including but not limited to, auditory and visual privacy. The patient's privacy shall also be respected when the facility personnel are discussing the patient.
11. To not be required to perform work for the facility unless work is part of the patient's treatment, and the work is performed voluntarily by the patient. Such work shall be in accordance with local, state, and federal laws and rules.
12. To exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices or any attendance at religious services shall be imposed upon the patient.
13. To not be discriminated against because of age, race, religion, sex, nationality, ability to pay, or be deprived of any constitutional, civil and/or legal right solely because of receiving services.
14. To expect and receive appropriate assessment management and treatment of pain as an integral component of that person's care in accordance with N.J.A.C. 8:43E6.

Patient Signature **Date**

All complaints may be files at the address listed below:

Division of Health Facilities Evaluation and Licensing
Elderly NJ State Department of Health
CN 367
Trenton, NJ 07625-0367
Telephone: 800-792-9770

Office of the Ombudsman for the Institutionalized
State of New Jersey
CN 808
Trenton, NJ 07862
Telephone: 800-624-4262

Patient Consent Form

The department of Health and Human Services has established a "Privacy Rule" to help ensure that personal information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain healthcare providers to obtain their patients' consent for uses and disclosures of Health Information about the patient to carry out treatment, payment or healthcare operations.

As our patient, we want you to know that we respect the privacy of your personal medical information, and we will do all we can to secure and protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of our healthcare information about treatment, payment or healthcare operations, in order to provide healthcare that is in your best interest.

We also want you to know that we support you with full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients) and may have to disclose personal health information for purpose of treatment, patient or healthcare operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent to this document, at some future time you may request to refuse all or part of your PHI. You may revoke actions that have already been taken which relied on this or previously signed consent.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Patient's Name (*print*): _____

Date: _____

Signature of Patient and or/Guardian: _____

Revised 11/21/2023