UNIVERSAL IMAGING CENTER

Medical Services Rendered
For X-Rays

Patient (Paciente):_____ **Date of Injury** (Fecha de Herida):_____

Date of Service: _____ **Our File #**: _____

I hereby authorize Universal Imaging Center to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved. (Por la presente autorizo al **Universal Imaging Center** a proporcionarle a usted, mi abogado, un informe completo de su examen, diagnóstico, tratamiento, pronóstico, etc., de mí mismo con respecto al accidente en el que estuve involucrado.)

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owning him for medical services rendered me both by reason of this accident and by reason of any other bills that are due his office and withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. I hereby further on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, as the result of the injuries for which I have been treated or injuries in connection therewith. (Por la presente le autorizo y le ordeno a usted, mi abogado, que pague directamente a dicho médico las sumas que le correspondan y que lo posea por los servicios médicos que me prestaron ambos en razón de este accidente y en razón de cualquier otro recibo que deba pagarle y retenerlo. tales sumas de cualquier acuerdo, juicio o veredicto que sean necesarios para proteger adecuadamente a dicho médico. Continuamente en mi caso a dicho doctor contra cualquier producto de mi acuerdo, fallo o veredicto que pueda ser pagado a usted, mi abogado, como resultado de las lesiones por las cuales he sido.)

I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him. (Estoy de acuerdo en no rescindir este documento y que mi abogado no cumplirá con la rescisión. Por la presente, doy instrucciones de que, en caso de que se sustituya a otro abogado en este asunto, el abogado respete este derecho de retención como inherente al acuerdo y ejecutable en el caso como si fuera ejecutado por él.)

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for services rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. Services rendered to me and this agreement is solely for Universal Imaging Centers' additional protection. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. (Entiendo completamente que soy responsable directa y directamente con dicho médico de todas las facturas médicas presentadas por él por los servicios prestados a mí y que este acuerdo se realiza únicamente para la protección adicional de dicho médico y en consideración de su pago pendiente. Además, entiendo que dicho pago no depende de ningún acuerdo, juicio o veredicto por el cual eventualmente pueda recuperar dicha tarifa. Los servicios prestados a mí y este acuerdo son exclusivos para la protección adicional de Universal Imaging Centers. Además, entiendo que dicho pago no está sujeto a ningún acuerdo, juicio o veredicto por el cual eventualmente pueda recuperar dicha tarifa.)

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but will require me to make payments on a current basis. (Por favor, reconozca esta carta firmando a continuación y regresando a la oficina del doctor. Se me ha informado que si mi abogado no desea cooperar para proteger los intereses del médico, el médico no esperará el pago sino que me exigirá que realice los pagos de forma corriente.)

_____ _____

Patient's Signature (Firma del Paciente) **Date** (Fecha)

The undersigned, being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to protect Universal Imaging Center at the time settlement funds are received by me. In the event that this case is transferred to another attorney, the undersigned attorney agrees to give notice of this lien and assignment of right to payment to any such new attorneys. (El abajo firmante, que es el abogado registrado del paciente anterior, acuerda observar todos los términos de lo anterior y acuerda retener tales sumas de cualquier acuerdo, juicio o veredicto que sea necesario para proteger el Centro de Imágenes Universales en el momento en que se liquiden los fondos. recibido por mi En el caso de que este caso sea transferido a otro abogado, el abogado abajo firmante acuerda notificar este gravamen y la cesión del derecho de pago a dichos nuevos abogados.)

_____ _____

Attorney's Signature Date

UNIVERSAL IMAGING CENTER

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For X-Rays

It is customary to pay for medical services as they are rendered.

Patient Information:
Patient Name: _____
Address: _____
City/State/Zip: _____
Phone: (_____) _____
Date of Birth: _____
Age: _____ Sex: □ M □ F
Social Security #: _____

Patient Status:

□ Single □ Married □ Other

□ Employed □ Part-Time Student □ Full-Time Student

If applicable complete below:

Accident Type: □ Auto □ Other
Date of Injury: _____
If auto, give state: _____
Is injury work related? □ Yes □ No
If work related, claim adjuster's name:
_____
Phone #: (_____) _____
Case Number #: _____

I authorize treatment of the patient named above.

I hereby assign all Medical Benefits to which I am entitled to *Universal Imaging Center*.

I understand that I am financially responsible for all charges incurred whether or not paid by insurance.

I hereby authorize the release of any information necessary to process my claim to my insurance carrier. I permit a photocopy of this authorization to be used in place of the original.

I hereby authorize *Universal Imaging Center* to obtain on my behalf, complete medical records, including x-rays and reports concerning my illness and/or treatment.

Signature: _____ Date: _____

UNIVERSAL IMAGING CENTER

Medical Services Rendered
For X-Rays

Medical History Questionnaire

_____ _____
Last Name First Name

Please answer the following questions:

1. What Part of your body is affected? _____

   _____

2. What are your symptoms (pain, swelling, dizziness, decrease in hearing or vision, etc.?

   _____

3. Did you have an injury or accident involving the affected part of the body? If yes, when was this

   injury? _____

4. Have you had surgery for this problem or any surgery in the past that might be related to the affected body part? _____

   _____

5. Please list any other important or pertinent information you can think of that would be of help in giving you the best answer and medical diagnosis: _____

   _____

6. Please list any allergies you have: _____

   _____

7. Are you pregnant or think you may be pregnant? Yes _____ No _____

   To the best of my knowledge, there is no possibility that I may be pregnant and wish to proceed with the Radiographic examination ordered by my Doctor with the understanding that in case of emergency, it can be dangerous and harmful to my unborn child.

_____ _____
Signature Date
(Parent or Guardian if minor)

UNIVERSAL IMAGING CENTER

Medical Services Rendered
For X-Rays

Assignment and Instruction for Direct Payment

To: _____
_____
_____

Re: Patient: _____ Insured: _____
SS No.: _____ Group/Policy #: _____
Employer:

I, the undersigned, hereby authorize **Universal Imaging Center** to furnish information to my insurance carrier(s) concerning this matter and do hereby irrevocably bargain, sell, convey and assign unto **Universal Imaging Center** my right, title and interest to those monies due me pursuant to medical pay provisions of my policies with all insurance companies providing benefits to me or others without regard or fault.
Further, I direct that said carrier(s) including Major Medical carrier(s) made Payment directly to **Universal Imaging Center**.
In the event my policy provides payment directly to me, I direct that said monies be paid to **Universal Imaging Center** and me jointly, and not otherwise. This joint payment is to be mailed directly to **Universal Imaging Center** only.

I further warrant and guarantee that I own the right that I am assigning and have neither been informed nor am I aware of any reservation, lien or other impairment affecting its validity, assignability or transferability.

I understand that I remain directly responsible to said **Universal Imaging Center** for fees or services rendered and that my obligation to pay such fees is not contingent upon the receipt of any settlement or recovery from any insurance carrier(s).

You are notified that this assignment comes within the scope of Section 10122 of the Insurance Code of California as amended on May 25, 1967, and further that the payment to the assignor after the date of this notice will subject you to double liability pursuant to the provision of the Civil Code of California, Section 954 and 955, as amended, and the cases interpreting them.

A photographic reproduction of this authorization and signature may be used in place of the original.

_____ _____
Insured/Patient (Guardian if Minor) Date

UNIVERSAL IMAGING CENTER

Medical Services Rendered
For X-Rays

DECLARATION OF PARTIES
PURSUANT TO LABOR CODE SECTION 4906 (g)

The undersigned do hereby swear/affirm under penalty of perjury, that he/she/they have not violated SECTION 139.3 and that he/she/they have not offered, delivered, received or accepted any rebate, refund, commission, preference, patronage, divided, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for any referred examination or evaluation.

_____ _____
PATIENT/APPLICANT DATE

_____ _____
FOR MEDICAL-LEGAL PRIVIDER DATE

REASON FOR ANY OMITTED SIGNATURE (UNDER PENALTY OF PERJURY)

UNIVERSAL
IMAGING CENTER

Medical Services Rendered
For X-Rays

Name of Patient: _____

The undersigned hereby acknowledges that the following medical services that are to be provided to the patient may not be covered services and may not be approved for payment under the insurance plan.

The undersigned agrees that he/she is financially responsible for the payment of all charges for these services:

_____
_____
_____

_____
Signature of Patient

Or

_____
Signature of Patient's Legal Representative

_____
Date

_____
Witness Print Name

_____
Witness Signature

5757 WILSHIRE BLD. SUITE 100 LOS ANGELES, CA 90036 *TEL:323-648 0500 FAX:323-648 0508*

UNIVERSAL IMAGING CENTER

Medical Services Rendered
For X-Rays

NOTICE OF PRIVACY POLICIES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

INTRODUCTION

At **Universal Imaging Center**, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. This Notice is effective 10-01-2008, and applies to all protected health information as defined by federal regulations.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit UNIVERSAL Imaging Center.

Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

-Basis for planning your care and treatment
-Means of communication among the many health professionals who contribute to your care.
-Legal document describing the care you received.
-Means by which you or third-party payer can verify that services billed were actually provided.
-A tool in educating health professionals.
-A source of date for medical research.
-A source of information for public health
-Officials charged with improving the health of this state and the nation.
-A source of data for our planning and marketing.
-A took with which we can access and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where and why others may access your health information and make more informed decision when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of **Universal Imaging Center**, the information belongs to you.

You have the right to:

-Obtain a paper copy of this notice of information practices upon request.
-Inspect and copy your health record as provided for in 45 CFR 164.524.
-Amend your health record as provided in 45 CFR 164.528.
-Request communications of your health information by alternative means or at alternative locations.
-Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522.
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

OUR RESPONSIBILITES

Universal Imaging Center is required to:

-Maintain the privacy of your health information.
-Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
-Abide by the terms of this notice.
-Notify you if we are unable to agree to requested restriction.
-Accommodate reasonable request you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail you a revised notice of the address you've supplied us, or if you agree, we will e-mail the revised notice to you.

We will not disclose your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH OPERATION

We will use your health information for treatment.
We will provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you.
We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team any use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

UNIVERSAL IMAGING CENTER

Medical Services Rendered For X-Rays

Business associates: There are some services provided in our organization through contact with business associates. There are some services provided in our organization through contact with business associates. Examples include physician services in the emergency department and radiology or a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.
Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care your location, and general condition.
Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify; health information relevant to that person's involvement in your care or payment related to your care.
Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.
Marketing: We may contact you to provide appointment reminders of information about treatment alternatives or other health-related services that may be of interest to you.
Fund raising: We may contact you as a part of a fund-raising effort
Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs or replacements.
Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.
Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.
Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.
Federal Law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provide that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

FOR MORE INFORMATION OR O REPORT A PROBLEM

If you have questions and would like additional information, you can file a complaint with this practice's Privacy Officer or with the office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a company with either the Privacy Officer or the Office for Civil Rights.

The address for OCR is listed below:
Office for Civil Rights
U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Room 509 F, H Building
Washington, D.C. 20201

ACKNOWLEDGEMENT OF RECEIPT

I have been presented with a copy of **Universal Imaging Center** Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice and I request the following restrictions(s) concerning the use of my personal medical information:
Further, I permit a copy of this authorization to be used in place of the original.

Signed: _____

Date: _____

If not signed by patient, please indicate relationship to patient (e.g., spouse or parent)

Relationship: _____

Witnessed by: _____
Internal Use Only:

If patient or patient's representative refuses to sign acknowledgment of receipt of notice, please document the date and time the notice was presented to patient and sign below.

Presented (date/time): _____

By (name/title): _____