JAN 11 2016

MEDFOCUS
2811 WILSHIRE BLVD., SUITE 900
SANTA MONICA, CA 90403
Phone:(800)398-8999

APPOINTMENT NOTICE

01/06/16

STOCKTON MRI MEDICAL CENTER
2320 N. CALIFORNIA ST, SUITE #2
STOCKTON, CA 95204

Claim Type : W/C
Referral # : 1486155
Medfocus Operator : ANA

Patient Information : TIFFANY ANDERSON
: 1900 LAKESHORE DR
: LODI, CA 95242
Home Phone : (209)331-0208
SSN :
Date of Birth : 08/22/70

Date Of Injury : 06/29/11

Type Of Exam : NM WHOLE BODY
: 78306 NM BONE SCAN WHOLE BODY *
Diagnosis : DERMATOLOGICAL ISSUES,RT KNEE PAIN,FATIG
Date/Time of Exam : 01/11/16 9:30 AM

Referring Physician : MICHAEL BRONSHVAG,
: 11010 WHITE ROCK RD. #120
: RANCHO CORDOVA, CA 95670
Phone : (800)458-1261
Fax : (916)920-2515

* PLEASE SUBMIT ORIGINAL FILMS AND REPORT TO THE REFERRING PHYSICIAN, UNLESS OTHERWISE REQUESTED.

**** FAX REPORT A.S.A.P. TO MEDFOCUS AT (888)754-7580 ****

Please submit study bill to:
Medfocus
2811 Wilshire Blvd., Suite 900
Santa Monica, CA 90403
Fax:(310)828-2253

If the patient cancels or reschedules, please call our toll free number (800)398-8999.

STOCKTON MRI &
Molecular Imaging Medical Center, Inc.

2320 N. California St., Stockton, Ca. 95204
Tel: 209-466-2000 • 800-270-2004 • Fax: 209-466-2600
www.stocktonmri.com

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REFERRING PHYSICIAN Bronshtag DATE _____

PATIENT NAME Anderson (Last) Tiffany (First) Kay (Middle Initial) ☐ Male ☐ Female

DATE OF BIRTH 8-22-70 AGE 45 HOME PHONE (209) 331-0208 WORK PHONE ( ) _____

MAILING ADDRESS 1900 (Street Address) Lakeshore Drive (Apt.#) Lodi (City) CA (State) 95242 (Zip Code)

PATIENT ADDRESS _____ (Street Address) _____ (Apt.#) _____ (City) _____ (State) _____ (Zip Code)

PATIENT SOCIAL SECURITY NUMBER _____

PATIENT EMPLOYER/SCHOOL _____

PLEASE CIRCLE THE APPROPRIATE ANSWERS. **HISTORY OF KIDNEY DISEASE OR DIABETES?** YES / NO
ARE YOU ALLERGIC TO? **SHELL FISH** YES / NO **IODINE** YES / NO **X-RAY CONTRAST** YES / NO
FEMALE PATIENTS ONLY: ARE YOU PREGNANT OR BREAST FEEDING YES / NO

PATIENT STATUS:
A. ☐ Single ☐ Married: ☐ Other
B. ☐ Employed ☐ Full-Time Student ☐ Part-Time Student

SPOUSE/PARENT _____ SOCIAL SECURITY# _____

DATE OF BIRTH _____ HOME PHONE ( ) _____ WORK PHONE ( ) _____

ADDRESS _____ (Street Address) _____ (Apt.#) _____ (City) _____ (State) _____ (Zip Code)

EMPLOYER _____

PERSON RESPONSIBLE FOR PAYMENT _____ RELATIONSHIP _____

PATIENT'S PRIMARY INSURANCE _____

PATIENT'S SECONDARY INSURANCE _____

IS THIS RELATED TO AN INJURY? ☐ Yes ☐ NO DATE OF INJURY _____

WHAT TYPE? JOB _____ AUTO _____ OTHER (PLEASE DESCRIBE) _____

NAME OF CARRIER _____

MAIL ADDRESS _____

CLAIM NUMBER _____ PHONE ( ) _____ EXT _____

CONTACT PERSON/ADJUSTER NAME _____

_____
RECEPTIONIST INITIALS

-OVER-

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NOTICE TO ALL MEDICARE PATIENTS

❑ Medicare will only pay for services that it determines to be "reasonable and necessary" under section 1862 (a)(1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under Medicare Program standards, Medicare will deny payment for that service.

I have been notified by this Medicare provider (Stockton MRI & Molecular Imaging Medical Center, Inc.) that Medicare is likely to deny payment for the services listed below, for the denial reason listed below. IF MEDICARE DENIES PAYMENT, I AGREE TO BE PERSONALLY AND FULLY RESPONSIBLE FOR PAYMENT.

Procedure Description: #_____ _____ $_____
(CPT Code) *(Description)* *(Charge)*

Denial Reason:_____

1. MR Angiography - Medical Necessity and/or Not Covered
2. Chiropractor Referrals
3. Clinical indications that do not meet "reasonable and necessary" Medicare guidelines.
4. Other: _____

PATIENT OR RESPONSIBLE PARTY

❑ I hereby authorize any holder of medical information to release to my insurance company and/or agents or the Health Care Financing Administration and its agents, any information needed to determine the benefits or the benefits payable for related services.

I hereby authorize and request payment of medical benefits directly to Stockton MRI & Molecular Imaging Medical Center, Inc., for services itemized on said claim.

I understand that I am responsible for the payment of any non-covered services, deductible, co-payments, or ineligibility upon determination by the insurance carrier.

I understand that I am responsible for payment of my account regardless of insurance coverage.

I do hereby authorize Stockton MRI & Molecular Imaging Medical Center, Inc., to obtain any medical information and/or films concerning myself/other _____
(State Patient Name and Relationship to Insured)

that is pertinent to the interpretation, evaluation and/or performance of any radiological procedure provided by Stockton MRI & Molecular Imaging Medical Center, Inc.

X _____ Patient's Birth Date 8-22-70
(Patient or Responsible Party's Signature for a minor)

_____
(Please Print Name of Responsible Party and/or Insured's Name

JAVAD JAMSHIDI, M.D.
JACK L. FUNAMURA, M.D.
FRANCIS P. ISIDORO, M.D.
BRIJ KAPADIA, M.D.
DOUGLAS MCGIRR, M.D.

STOCKTON MRI &
Molecular Imaging Medical Center, Inc.
2320 N. California St., Stockton, Ca. 95204

JAN 11 2016

Tel: (209) 466-2000
(800) 270-2004
Fax: (209) 466-2600

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patients Rights section describing your rights under the law. You have the right to review our Notice prior to signing the Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree with this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information (PHI) about you for treatment, payment and health care operations. You have the right to revoke the Consent, in writing, signed by you. However, such a revocation shall not affect any disclosure we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

THE PATIENT UNDERSTANDS THAT:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The Patient has the right to restrict the users of their information but the Practice does not have to agree to those restrictions.
- The Patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon execution of this Consent.

This Consent was signed by: _____
Printed Name-Patient or Representative

Tiffany Andrew 1,11,16
Signature **Date**

(if other than patient) : _____

****

Do we have your permission to:

Leave a message on your answering machine at home? X YES ___ NO
Leave a message at your place of employment? ___ YES ___ NO
Discuss your medical condition with any member of your household? X YES ___ NO

If yes, whom: John Sales **Relationship** boyfriend

Patient Signature

1-11-16
Date