

I-MAGING

Conditions of Service

PATIENT _____ DOB _____ ACCT# _____

Assignment of Benefits

I, or authorized representative/legal guardian acting on behalf of the patient hereby authorize payment of insurance benefits under the terms of my policy directly to 1960 Digital Imaging and/or I-Imaging (the "facility") for services rendered. I am financially responsible and will pay for charges not covered by my insurance plan.

Financial Agreement and Statement of Responsibility

For and in consideration of services rendered or to be rendered the facility, I agree to pay said clinic for all services and charges. I understand that I am responsible for any health insurance deductibles, coinsurance and non-covered charges. **I understand payment in full is due at the time services are rendered or payment arrangements are to be made before my appointment. I understand that the amount quoted by the facility as being my responsibility is an estimate only and any patient balance remaining after my insurance has processed my claim will be billed to me and due within 30 days.**

I understand that it is my responsibility to inform the office with a minimum of a 24 hour advance notification if I am unable to make my appointment. I understand that I will be charged a fee for not giving proper notification.

X _____

Patient/Guarantor Signature

_____ Date

Consent to Medical Treatment by Physician

I, or authorized representative/legal guardian acting on behalf of the patient, do hereby consent to receiving general medical services, which may include routine diagnostic procedures and such medical treatment as the physician, his/her assistants or his/her designees consider to be necessary in his/her judgment. I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to results of treatment or examination at the facility.

X _____

Patient/Guarantor Signature

_____ Date

Acknowledgement of Review of Privacy Practices

I, the undersigned, have reviewed the Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of the Privacy Practices.

Release of Patient Healthcare Information

I hereby authorize the facility and any subcontractor of, **to release or obtain** patient healthcare information, in accordance with the policy of the clinic, as is necessary to health care providers to facilitate reimbursement by a health benefit plan or personnel of another health care entity for the purpose of providing current continuum of care including to facilitate reimbursement by a health benefit plan or third party payor, including but not limited to, my insurance carrier, Medicare, Medicaid, and any other payer or agency.

X _____

Patient/Guarantor Signature

_____ Date

The above authorizations are valid unless you revoke them in writing.