# *Patient Authorization and Responsibility Form*

Patient Name: ______________________________________ Patient Account Number: _______________________

I, the undersigned, in consideration of the provision of ___________________________________________________
(the "procedure') by INSIGHT IMAGING ("Center") hereby acknowledge and agree to the following terms and conditions:

**Consent to Procedure:** I hereby consent to and authorize the Center to perform the procedure in accordance with the general and special instructions of my treating physician or the physician supervising the procedure. I also acknowledge that my physician has fully explained to me the procedure and all risks, benefits and any alternative procedures.

**Authorization/Assignment of Benefits**: I hereby authorize and assign payment of any benefits due me under the terms of any insurance policy or policies that may cover the procedure performed on me or my dependent(s) by Center directly to Center at the address designated by Center on any claim form submitted to my insurance carrier. I agree that payment to Center pursuant to this authorization/assignment by my insurance company shall discharge said insurance company of any and all obligations under the policy to the extent of such payment. I understand and agree that I am financially responsible for charges not covered by this authorization/assignment and I authorize Center to contact my employer for the purpose of determining the existence and extent of any insurance benefits. I understand that my insurance company is being billed as a courtesy and I agree that I am financially responsible to pay for any charges not covered by my insurance company. Should my account become delinquent, I agree to pay interest on the outstanding balance owed at the maximum amount permitted by law. If Center undertakes collection efforts to recover any past due amounts, I agree to pay all reasonable costs incurred, including attorney's fees.

**Responsibility for Valuables**: I hereby understand and acknowledge that Center is not responsible for the loss of, damage to, or theft of any of my, or and my dependent's, personal possessions, including, but not limited to, money, jewelry, clothing or other valuables, while I or my dependents are on Center's premises.

**Authorization/Consent to Release Information**: I hereby authorize any insurance company, prepayment organization, employer, hospital, physician, or utilization review representative to release to Center any and all information with respect to me or my dependent(s) which may have a bearing the treatment I or my dependent(s) receive at the Center or on any benefits payable by my insurance company for the procedure performed by Center on me or my dependent(s). I agree that this authorization shall remain effective for one (1) year from the date indicated below. I hereby authorize Center to release to my insurance company or to any physician or other healthcare provider providing treatment to me or my dependent(s) all information with respect to me or my dependent(s) which may be necessary for the provision of health care services to me or my dependents or regarding benefits payable to me or my dependent(s).

**Notice of Privacy Practices:** I acknowledge that I have been provided with a copy of the Center's Notice of Privacy Practices. I acknowledge that I have reviewed the Notice of Privacy Practices prior to signing this consent. I understand that Center reserves the right to change its Notice of Privacy Practices without notice to me.

**For Medicare Patients Only - Authorization to Release Information and Payment Request**: I hereby request that payment of authorized Medicare benefits be made on my behalf to Center for any services rendered by Center. I hereby authorize any holder of medical or other information about me to release to the Health Care Financing Administration or its agents, intermediaries or carriers any information needed to determine these benefits or the benefits payable for related services. I further understand that deductibles, coinsurances and any other charges not covered by Medicare are my responsibility.

| ________________________________ | ________________________________ | __________ |
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| Patient or Legal Representative Signature | Print Name and Authority (If legal representative) | Date |

Revised 04/01/2003