Account #

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION/FINANCIAL RESPONSIBILITY

Patient Name

Date

I hereby authorize Partners Imaging Center to provide treatment and/or examination, and release any pertinent information to my physicians, insurance company, adjustor or attorney if applicable, and to apply for Medicare/Medicaid, and other health insurance benefits if applicable, (No fault, Personal Injury Protection and Workers Compensation) on my behalf and to take all necessary steps to collect such benefits, including but not limited to filing for arbitration as provided by statutes, I hereby authorize payment of any/all medical benefits and insurance proceeds be made on my behalf to the above. I certify that the information I have reported the release with regard to my insurance carrier(s) is correct. I authorize the release of medical information about me to my physicians, health insurance carrier and the Center for Medicare and Services (CMS) agents, and any and all other information needed to determine the benefits payable for related service(s) If medical insurance information is received at the time of service, as a courtesy, all claims will be submitted to your insurance company. Insurance co-payments and annual deductibles not met for the year are payable when services are rendered. Any services that are not fully reimbursed by your insurance carrier and are indicated on your insurance's Explanation of Benefits to be the patient's responsibility will be due and payable upon receipt of a billing statement. Also please be aware that this imaging center will not forgive patient deductibles, patient co-payments, and patient co-insurance payments. It is against the law.

Signature of Patient/Parent/Guardian

Date

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

By signing below, I hereby acknowledge receipt of Partners Imaging Center Notice of Privacy Practices.

Signature of Patient/Parent/Guardian

Date