Account#_____

ASSIGNMENT OF BENEFITS / RELEASE OF INFORMATION / FINANCIAL RESPONSIBILITY

_____ _____

Patient Name: **Date:**

I hereby irrevocably authorization Partners Imaging Center to provide treatment and/or examination, and release any pertinent information to my physician, insurance company, adjustor, or attorney if applicable. To apply for Medicare/Medicaid, and other health insurance benefits, if applicable, (No Fault, Personal Injury Protections, 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 statues. 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 with regard to my insurance carriers(s) is correct. I authorize the release of medication 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 carriers and are indicated on you insurances Explanation of Benefits are to be the patient's responsibility and will be due and payable upon receipt of a billing statement. Also, please be aware that this imaging center will not forgive patient deductible, patient co-payments, and patient co-insurance payments. It is against the law.

_____ _____

Signature of Patient / Parent / Guardian **Date**

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES

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

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Signature of Patient / Parent / Guardian **Date**