VISION IMAGING | a Rezolut partner

Date of Birth:
Medical Record #:
Referring Physician:

Treatment, Insurance, & HIPAA Authorization

Authorization for Treatment

I hereby consent to treatment by the attending physician and other medical staff for all local anesthetics, tests, surgical, and other medical procedures as deemed necessary by myself and the medical staff.

Authorization for Release of Information and Assignment of Benefits

I hereby assign to the above named office, those benefits otherwise payable to me by any third party as reimbursement of expenses and fees in connection with treatment rendered.

I request that payment of authorized benefits be made directly to the medical provider named above on my behalf.

I FULLY UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY AND ALL AMOUNTS NOT OTHERWISE PAID BY MY INSURANCE CARRIER.

I certify that the information on this form given by me for payment under title XVIII (Medicare) is correct and complete. I authorize the holder of medical or related information about me, to be released to the Health Care Finance Administration or other health care coverage entity, any information needed for this or any related health care claim in writing or verbally. I further understand and agree to pay for services or amounts due when appropriate. These charges could include amounts applied to my annual deductible co-payment amounts, and charges denied as not covered by my insurance program or deemed medically unnecessary. I understand that well care is not covered by Medicare or many other health insurance programs.

I hereby authorize the release of my films and/or medical records as needed for subsequent medical care. In the event of positive findings, I authorize my attending physician to release the results of my biopsy-surgery to the provider named above for their records.

If someone other than the patient is signing this authorization, please state relationship with patient and the reason patient is unable to sign.

Signature _____ **Date Signed:** _____

HIPPA NOTIFICATION

I acknowledge the receipt of the Notice of Privacy Practices for the Imaging Center.

Signature _____ **Date Signed:** _____
Patient/Parent/Guardian

For Females only: **PREGNANCY STATEMENT**

To the best of my knowledge, I am not pregnant. **Date of LMP:** _____

Signature _____ **Date Signed:** _____