ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION/ FINANCIAL RESPONSIBILITY

I hereby irrevocably authorize Advanced Shore Imaging Associates and/or its designees to provide treatment and/or examination, and release any pertinent information to my physician, 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 & 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 with regard to my insurance carrier(s) is correct. I authorize the release of medical information about me to my physician, health insurance carrier and the Center for Medicare & Medicaid 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, a claim 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 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 center will not forgive patient deductibles, patient co-payments, and patient co-insurance payments. It is against the law.

If you do not have medical insurance, financial arrangements will be made prior to services rendered. Otherwise, full payment will be expected at the time of services.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES and BILL OF RIGHTS

By signing below, I hear by acknowledge receipt of Notice of Privacy Practices and the Patient Bill of Rights.

CONSENT FOR A MINOR FOR A DIAGNOSTIC IMAGING PROCEDURE

The procedure has been explained in detail and I, as the legal guardian/parent of the patient named above, understand it and agree to it. I hereby give my informed consent for this study to be performed (if applicable).

NOTICE OF HIPAA PRIVACY PRACTICES

I hereby acknowledge receipt of Advanced Shore Imaging Associates Notice of HIPPA Privacy Practices/Joint HIPPA Privacy Notice. I understand this consent serves as a complete release of liability to Advanced Shore Imaging Associates and its employees for the release of information, and/or digital media (CDs) or films. I understand that I have the right to revoke this authorization, in writing at any time. I understand the revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorizations was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. Unless otherwise revoked, this authorization shall be in force and effect one year from today's date at which time authorization expires.

RECORD RELEASE AUTHORIZATION

I do hereby authorize Advanced Shore Imaging to disclose/request information from my medical record relating to my diagnostic study. I understand that this consent will serve as a complete release of liability to Advanced Shore Imaging and its employees for the release of information/films/CD.

Patient Name:
Patient DOB:
Date: