AUTHORIZATION OF BENEFITS

CONSENT FOR CARE/DIAGNOSTIC TREATMENT
I have presented to Stat Imaging with a condition that may require treatment/diagnostic procedures. I voluntarily consent to treatment or procedures, which may be necessary in the opinion of the attending physician or his/her designee who is assigned to supervise my care. I understand that treatment and diagnostic procedures will be performed under the direction of a licensed physician or his/her designee. I acknowledge that no guarantee or warranty has been made regarding the results of any treatment/procedures, which may be performed.

ASSIGNMENT OF INSURANCE BENEFITS
I authorize payment to be made directly to Stat Imaging under the insurance coverage(s) identified for this encounter. I understand I am financially responsible for all charges not reimbursed by my insurance coverage.

STATEMENT TO PERMIT PAYMENT OF MEDICARE/MEDICAID BENEFITS TO PROVIDER, PHYSICIAN, AND PATIENT
I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical and other information about me to release to the Health Care Financing Administration or it's intermediaries or carries any information needed for this or a related Medicare/Medicaid claim. I request that payment of authorized Medicare/Medicaid benefits be made on my behalf, for any services furnished me by Stat Imaging, directly to Stat Imaging.

FINANCIAL AGREEMENT
I agree whether signing as patient or agent of the patient that in consideration of the services to be rendered, I am obligated to promptly pay the account of Stat Imaging in accordance with the regular rates and terms of Stat Imaging. Payment arrangements must be made in agreement with Stat Imaging.

AUTHORIZATION FOR RELEASE OF INFORMATION FOR REIMBURSEMENT
Stat Imaging is authorized to disclose all or any part of the medical record of this encounter for this patient to any insurance company, organization, or agency that may be responsible for the payment of costs incurred for this encounter. The medical record may/may not contain information related to diagnosis and treatment of psychiatric disorders, substance abuse and/or HIV/AIDS. The information will be disclosed under applicable State Laws and Federal Laws including 42 C.F.R. Part 2.

Do you have a Living Will (Advance Directive)? _____☐ no _____☐ yes
Would you like information on a Living Will (Advance Directive)? ___☐ no ___☐ yes

☐ _____
Signature of Patient/authorized representative Date

_____ _____
Relationship to patient Reason Patient Unable to Sign

_____
Witness Date