

**AUTHORIZATION FOR RELEASE OF MEDICAL  
INFORMATION AND PROMISE TO PAY FOR ALL  
REASONABLE AND NECESSARY MEDICAL EXPENSES  
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

**INDEPENDENT MRI IS NOT A PHYSICIAN'S OFFICE THAT IS SUBJECT TO PHYSICIAN (PRIMARY CARE OR SPECIALIST) CO-PAYS. YOUR PATIENT RESPONSIBILITY FOR PAYMENT WILL DEPEND UPON YOUR INSURANCE PLAN COVERAGE. YOU MAY HAVE A CO-PAY, A CO-INSURANCE AMOUNT AND/ OR A DEDUCTIBLE AMOUNT THAT MUST BE PAID.** You are responsible for payment of all services provided by Independent MRI including payment of co-payments, co-insurances and deductibles. Should your insurance carrier fail to pay within a reasonable time, you will need to make specific arrangements with Independent MRI for the payment of your bill. Arrangements include, but are not limited to, a promise by your attorney to withhold proceeds of settlement for payment. Statements are sent at the first of each month. Payment is due upon receipt of statement unless arrangements are made. \_\_\_\_\_ INITIALS

**FOR WORKER'S COMPENSATION/PERSONAL INJURY BILLING ONLY**

I understand that the policy of Independent MRI is to obtain my **worker's compensation/personal injury** billing information for my injury on \_\_\_\_\_ (date of injury) before services are provided. I understand that Independent MRI does not accept third-party claims, or claims of which the payer has not been established. I agree to the release of all medical information to the payer of the claims, as it is required for the assignment of benefits. I agree that services rendered by Independent MRI shall be reimbursed before receiving my settlement monies.

**CONSENT, AUTHORIZATION, RELEASE, ASSIGNMENT & ACKNOWLEDGMENT**

1. I authorize Independent MRI employees, physicians and designees to perform the medical testing ordered by my provider, to administer treatment, medication, or any procedure deemed necessary in the care and management of my case, and to release the results of such tests to my provider.
2. I hereby give lifetime authorization for payment of insurance benefits, whether it be worker's compensation carrier; automobile medical insurance carrier; or other medical insurance carrier (including Medicare or Medicaid); or my attorney, to be made directly to Independent MRI for services rendered. I understand that should my insurance company not honor this assignment of benefits, I will immediately forward any insurance payment received for services rendered by Independent MRI to Independent MRI.
3. I authorize Independent MRI staff to request previous MRI/medical records from any facility necessary to complete testing.
4. I authorize Independent MRI to release any information necessary to facilitate billing and reimbursement directly to Independent MRI. I authorize holders of medical information about me to release to Independent MRI any information needed to determine these benefits or the benefits payable for related services.
5. I agree to pay all legal expenses and costs incurred should this account be referred to a collection agency. Unpaid balances over 60 days will be reported to an outside collection agency unless previous arrangements have been made for payment of account.
6. I agree that a photocopy of this form may be used in lieu of the original.
7. I have read the Notice Of Privacy Practices posted in the waiting area, and understand the possible uses of my protected health information. I have been offered a copy of the Notice of Privacy Practices on the date indicated below. I understand that I can obtain a copy of the Notice Of Privacy Practices upon request.
8. Independent MRI is allowed to release my personal medical information to the following persons (such as a family member or trusted friend):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Patient Signature** (if a minor, parent must sign)