

**AUTHORIZATION FOR RELEASE OF MEDICAL  
INFORMATION AND PROMISE TO PAY FOR ALL  
REASONABLE AND NECESSARY MEDICAL EXPENSES**

**I UNDERSTAND THAT INDEPENDENT MRI CENTER, LLC (INDEPENDENT MRI) IS AN OUTPATIENT RADIOLOGY FACILITY. 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. \_\_\_\_\_ (INITIAL)**

**CONSENT, AUTHORIZATION, RELEASE & ASSIGNMENT**

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 authorize Independent MRI staff to request previous x-ray/medical records from any facility necessary to complete testing.
3. I authorize Independent MRI to release any information necessary to facilitate billing and reimbursement directly to Independent MRI.
4. I request that payment of insurance benefits by my insurance carrier: whether it be worker's compensation carrier; automobile medical insurance carrier; or other medical insurance carrier (including Medicare or Medicaid); or my attorney, to make payments for reasonable and necessary medical treatment 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 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.
6. I understand that I am responsible for payment of all services provided by Independent MRI including payment of co-payments, co-insurances and deductibles. I further understand that should my insurance carrier fail to pay within a reasonable time not to exceed sixty (60) days from the date of service, I will make specific arrangements with Independent MRI for the payment of my bill. Arrangements include, but are not limited to, a promise by my attorney to withhold proceeds of settlement for the payment of my reasonable and necessary medical expenses by another party. Should the account be referred to a collection agency, I agree to pay all reasonable fees and collection expense.
7. I agree that a photocopy of this form may be used in lieu of the original.
8. I have read the Notice Of Privacy Practices posted in the waiting area, and understand the possible uses of my protected health information. I understand that I can obtain a copy of the Notice Of Privacy Practices upon request.
9. Independent MRI is allowed to disclose my personal medical information to the following persons:

\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
**Patient**

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

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.

\_\_\_\_\_  
**Patient Signature**