Impression:Imaging

CT • PET • CTA

PATIENT INFORMED CONSENT – FINANCIAL AGREEMENT
PATIENT RELEASE OF INFORMATION

Patient Name:_____ DOB: _____ MRN: _____
Center Name: **IMPRESSION IMAGING, LLC**

General Medical Consent: I hereby authorize the professional staff and physicians in charge of the care of the above named patient to carry out such diagnostic procedures and/or radiological examinations, including the use of oral or intravenous contrast, as requested by my family/specialist physician for the purpose of diagnosis and treatment. I have obtained written information about the procedure and have been given the opportunity to ask pertinent questions and have received satisfactory explanations.

Release of Information: This authorization or photocopy thereof will authorize the release of full and complete medical records/reports and any other records when necessary to governmental agencies, insurance carriers and review agencies for payors responsible for precertification and payment for services rendered. I also authorize the Center to permit such payors and their review agencies to examine and make copies of my records as requested for payment as permitted by Federal and State law. I further authorize release of previous medical records as requested by the Center. In addition, I authorize the release of complete medical records to my treating physician and/or consulting physician representing themselves to be involved in my case and/or treatment.

Assignment of Medicare Benefits: I hereby authorize payment directly to the Center written above in the event of insurance benefits to myself. I agree to authorize release of the explanation of insurance benefits. In the event of any refusal of any insurance company or attorney to pay the bill, I agree to pay the balance owing, including any insurance denials for medical necessity, if applicable. I hereby agree to be responsible for said debt and any collection fees involved in the collection of this debt.

Assignment of Medicare Benefits: Patient Certification: 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 or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related claim. I request the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services or authorize such physician or organization to submit a claim to Medicare for payment to me. I understand that I am responsible for Part B deductible for each year, the remaining 20% of reasonable charges and any personal or non-covered charges incurred.

Acknowledgement of Medicare: I hereby declare I am a participant in the Medicare program and am not enrolled in a Health Maintenance Organization (HMO) or any other Pre-Paid group practice. I understand that if it is found that I am a participant in any of the above mentioned practices, I will be a considered Self-Pay patient and required to pay in full immediately if services are denied.

Assignment of Medigap Benefits: I request that payment of authorized Medigap benefits be made on my behalf to the Center written above for any services furnished to me by that Center. I authorize any holder of medical information about me to release any information needed to determine these benefits or the benefits payable for related services. I understand that I do not need to provide my supplemental insurer with information concerning this Medicare claim because my signing this authorization will cause Medicare payment information to cross over automatically.

Name of Medigap Company: _____
Medigap Policy Number: _____

Patient Rights: I have received a copy of my patient rights and responsibilities.

Patient Signature	Date
Guarantor/Guardian Signature	Date
Witness	Date

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