Patient Authorization and Financial Responsibility Form

Patient Name _____
DOB_____

I, the undersigned, as it relates to the following service _____

(The "procedure(s)") by Bear MRI and Imaging (the "**CENTER**") **hereby acknowledge and agree to the following terms and conditions:**

Consent to Procedure: **I hereby consent to authorize the center to perform the procedure in accordance with the general and special instructions of my treating physician or the physician supervising the procedure. I acknowledge that my physician has fully explained to me the procedure and all risks, benefits and any alternative procedures.**

NOTICE OF PRIVACY PRACTICE: **I acknowledge that upon request, the *CENTER* will provide me a copy of the *CENTER'S* notice of privacy practices. I acknowledge that I am permitted to receive the Notice of Privacy Practices prior to signing this consent. I understand that the *CENTER* reserves the right to change its Notice of Privacy Practice without notice to me.**

RESPONSIBILITY FOR VALUABLES: **I hereby understand and acknowledge that the CENTER is not responsible for loss, damage or theft of any of my or my dependents personal possessions. This includes but not limited to money, jewelry, clothing or other valuables while I and dependents are in the *CENTER*.**

AUTHORIZATION/CONSENT TO RELEASE INFORMATION: **I hereby authorize any insurance company, prepayment organization, employer, hospital, physician or utilization review representative to release to the *CENTER* any and all information with respect to me or my dependents which may have a bearing on the treatment that I or my dependents receive at the *CENTER* or any benefits payable by my insurance company for the procedure performed by the *CENTER* on me or my dependents. I hereby authorize *CENTER* to release to my insurance company or to any physician or other healthcare provider providing treatment to me or my dependents all information with respect to me or my dependents which may be necessary for the provision of healthcare services to me or my dependents or regarding benefits payable to me or my dependents.**

_____ _____
Patient Signature (*or Parent/Guardian if a minor*) ***Date***

Financial Responsibility Statement/Insurance Assignment:

I accept responsibility to insure that payment is made for all services rendered.
I hereby authorize and assign payment of any benefits due me under the terms of any insurance policy or policies that may cover the procedure performed on me or my dependent (s) by *CENTER* directly to the *CENTER* at the address designated by the *CENTER* on any claim form submitted to my insurance carrier. I understand and agree that I am financially responsible for charges not covered by this authorization/assignment. I understand that my insurance company will be billed for the services received today and I agree that I am financially responsible to pay for any charges not covered by my insurance company. I understand that it is my responsibility to pay the deductible, co-insurance, co-pay, or any balance not paid by insurance. All balances that reach 90 days past due will be sent to a collections agency. Should my account become delinquent, I agree to pay interest on the outstanding balance owed at the maximum amount permitted by law. If the *CENTER* undertakes collection efforts to recover any past due payments, I agree to pay all reasonable costs incurred by the CENTER, including collection and attorney's fees.

_____ _____ _____
Signature (of Responsible party) ***Print Name*** ***Date***