BAY RADIOLOGY San Ramon

Patient Authorization and Responsibility Form

Patient Account Number: _____

Print Name: _____ Date: _____

I, the undersigned, in consideration of the provision of _____ (the "procedure") by Bay Radiology San Ramon (the "Center") hereby acknowledge and agree to the following terms and conditions:

Consent to Procedure: I hereby consent to and 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 also acknowledge that my physician has fully explained to me the procedure and all risks, and any alternative procedures.

Authorization/Assignment of Benefits: 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 the Center directly to the Center at the address designated by the Center on any claim form submitted to my insurance carrier. I agree that payment to the Center pursuant to this authorization/assignment by my insurance company shall discharge said insurance company of any and all obligations under the policy to the extent of such payment. I understand and agree that I am financially responsible for charges not covered by this authorization/assignment and I authorize the Center to contact my employer for the purpose of determining the existence and extent of any insurance benefits. I understand that my insurance company is being billed as a courtesy and I agree that I am financially responsible to pay for any charges not covered by my insurance company. 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 amounts, I agree to pay all reasonable costs incurred, including attorney's fees. In the event there is ever a positive balance in my account with Insight Imaging, Insight Imaging may apply the amount of such positive balance to any unpaid balance for any services rendered by Insight Imaging to me or my dependent(s).

Responsibility for Valuable: I hereby understand and acknowledge that the Center is not responsible for the loss of, damage to, or theft of any of my or my dependent's personal possessions, including but not limited to, money, jewelry, clothing, or other valuables, while I or my dependent(s) are on the Center's premises.

Notice of Privacy Practices: I acknowledge that I have been provided with a copy of the Center's Notice of Privacy Practices. I acknowledge that I have received the Notice of Privacy Practices prior to signing this consent. I understand that the Center reserves the right to change its Notice of Privacy Practices without notice to me.

For Medicare Patients Only – Authorization to Release Information and Payment Request: I hereby request that payment of authorized Medicare benefits be made on my behalf to the Center for any services rendered by the Center. I hereby authorize any holder of medical or other information about me to release to the Health Care Financing Administration or its agents, intermediaries or carriers any information needed to determine these benefits or the benefits payable for related services. I further understand that deductibles, coinsurances and any other charges not covered by Medicare are my responsibility.

Patient or Legal Representative Signature	Print Name (and Authority if Legal Representative)	Date