OAKLAND MRI CENTER, LLC RELEASE AND AUTHORIZATION

Authorization for Treatment: I present myself or child for whom I am guardian for diagnostic procedure(s) as may be ordered by the referring physician, his assistants, or his designee and authorize any emergency medical care. I am aware that practice of medicine is not an exact science and I acknowledge that no guarantee has been made to the results of examination by the center.

Authorization for Release of Information: I authorize the center to disclose all or any parts of the patient's medical record to listed insurance companies, government agencies, the patient's employer or conducting reviews concerning Worker's Compensation care and any review agency which conducts practice utilization review under an agreement with the patient's employer or other payment source. I also understand that I may revoke this authorization by providing written notice to this practice.

Medicare/Medicaid Patient's Certification: I certify that the information given by me in applying for payment under Title XVIII and XIX of the Social Security Act is correct. I request payment be make directly to the provider of services on my behalf and I authorize said provider to release any and all information necessary regarding the treatment and services provided as stated below.

Assignment of Benefits: I hereby authorize payment directly to the center by my insurance company(s). In the event an overpayment is made from more than one insurance company, I understand the overpayment will be sent to the appropriate payer.

Insurance: The center will file your insurance as a service to you. If our office does not hear from your insurance company within 30 days, we request your help in contacting your insurance company to resolve the payment delay. The insurance plan is a contract between you and your insurance company. We must hold you responsible for any balance due.

Payment of Services: I understand I am financially responsible for all charges and fees related to the services rendered to me by the center. I further understand that payment in full is expected upon receipt of the first statement which may include co-payments, deductibles and any services not covered by insurance.

Notice of Privacy Practices: I hereby acknowledge that I have received a copy of the centers privacy practices.

Valuables: I (we) understand that the center is not responsible for valuables and personal property brought to the facility.

Married or Dependent Patients: I hereby consent to the release of any patient-related or financial information about me to my spouse (if married) or to my parents (if a dependent child).

It is our policy to bill your insurance carrier as a courtesy to you; therefore, we request your signature below authorizing release of any medical or other information necessary to process your insurance claim and payment of those medical benefits paid directly to this provider. By your signature below, you or your legal representative acknowledge full responsibility for the payment at the time the service is rendered of any co-pay, deductible, and amount not covered by insurance. Your signature also authorizes consent for treatment and the release of medical records **to/from** other attending physicians and facilities.

The undersigned further expressly agrees that if, upon default, this matter is referred to an attorney or collection agency, or small claims court, the undersigned agrees to pay their account balance plus attorney's fees and cost of the outstanding balance at the time of referral, which percentage and the amount resulting therefrom are considered reasonable by the undersigned and any and all court costs incurred within.

Patient/Guardian Name (please print) _____

Signature _____ Date: _____

Address _____