Authorization and Consent

Patient Name (please print):____

Release of Information: I authorize Sugar Mill Diagnostic Imaging, L.L.C. and any other holder of information about me to disclose all or any part of my medical record or other information needed to determine my eligibility for benefits or the amount of benefits payable for Services rendered by Provider, now or in the future, to any financially responsible party, including but not limited to: the Centers for Medicare and Medicaid (CMS), Medicaid, their intermediaries or carriers, Worker's Compensation carriers, health or liability insurers, or any other insurance organization or billing agent. I authorize any holder of medical and billing information about me to release to Provider or any insurer any information any information necessary for billing and payment purposes. I certify that the information given by me is applying or payment in accordance to the Social Security Act is correct. I consent to the use of a copy of this authorization in lieu of the original.

Assignment of Benefits: I request and authorize direct payment to Provider of any Medicare and other insurance benefits payable to me or on my behalf got Services rendered by Provider, now or in the future. I understand that I am financially responsible to Sugar Mill Diagnostic Imaging, L.L.C. for charges not covered by this assignment or for any and all charges, which the insurance carrier declines to pay. It is further agreed that any credit balances resulting from payment of insurance or other source may be applied to any other accounts owed by the insured or his /her family.

Financial Responsibility: The undersigned agreed, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she obligates himself/herself to pay the account of Sugar Mill Diagnostic Imaging L.L.C., in accordance with the regular rates and terms. Should the account be referred to a collection agency and/or attorney collection, the undersigned shall pay reasonable attorney fees, collection expenses, and a returned check for $25 if applicable.

The undersigned certifies that he/she has read the foregoing, and is the patient, the patient's legal representative or is duly authorized by the patient as the patient's agent to execute this Authorization and Consent form and to except as noted below.

____ _____________________

Patient Signature **Date**

CONSENT FOR MINOR FOR DIAGNOSTIC IMAGING PROCEDURE(S):

____ _____________________

Parent/Guardian Signature **Date**