MADISON RADIOLOGY
Imaging Excellence with Personalized Care
2A Samson Rock Drive, Madison CT 06443
p) 203-245-7351 www.madisonradiology.com

Patient Name: _____ ***Date of Service***: _____

Consent for Treatment and Release of Information and Acknowledgment

Consent for Treatment: I hereby authorize the physicians of Madison Radiology to administer such treatment and medication as may be deemed necessary or advisable in the treatment and diagnosis of my condition.

Authorization for Release of Information for Treatment & Payment: I consent to the use and/or disclosure of my health information to any person or organization conducting certain healthcare operations for the purpose of treatment, including coordinating my continuing care and as otherwise authorized by law.

Financial Agreement: I understand I am obligated to pay Madison Radiology in accordance with the regular fee schedule and terms of the organization, and my insurance provider. I agree to pay Madison Radiology for all charges designated as patient responsibility no*t* paid by insurance benefits. I also authorize payment directly to Madison Radiology for services performed. To obtain payment for services, I authorize Madison Radiology to furnish and release to my insurance carrier(s) or their representatives insuring the patient named, any or all portions of my medical record which may be necessary for completion of my patient care insurance claims. In addition, should it become necessary, I authorize agents of Madison Radiology to make informational calls. I hereby release Madison Radiology from all legal liability that may arise from the release of the information requested and provided. A photocopy of this authorization shall be as binding as the original. If my account is not paid, I will pay all collection fees, court costs, attorney's fees and other costs incurred by Madison Radiology to collect the balance owed.

Assignment of Insurance Benefits: In consideration for services rendered or to be rendered, I hereby assign to Madison Radiology all insurance benefits, without limitation, Medicare or Medicaid benefits, to cover such services. In connection with such assignment, Madison Radiology is hereby authorized to contact my insurance carrier on my behalf and to obtain any and all such information as may be necessary to process any insurance claim related to my treatment.

Insurance Information: I understand that it is my responsibility to provide the correct Health Insurance Information to the provider of services. I further understand that if I provide the *incorrect* Health Insurance Information, I will be held liable for services not paid due to this error. I acknowledge the Precertification and/or insurance documentation does not always guarantee coverage. It is the patient's responsibility to verify their insurance coverage at our facility prior to testing.

Notice of Privacy Practices: I acknowledge that a copy of the Madison Radiology's Notice of Privacy Practices (NPP) is available to me upon request. Within The Notice of Privacy Practices and following the HIPPA guidelines, I also agree that you may use my information (email address) to inform me about treatment alternatives and health-related benefits and services that may be of interest to me. This may include treatments, services, products, other healthcare providers or special programs. My email address below signifies my agreement.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ, UNDERSTOOD, AND AGREES TO THE FOREGOING, AND IS THE PATIENT OR HIS/HER REPRESENTATIVE

Signature: _____ **Email:** _____ **Date:** _____

Signature of Patient or Person Granting Authorization on Behalf of Patient