Patient Agreement and Signature

_____I, the patient named below or the patient's authorized representative, understand that I am financially responsible to CNMRI, PA for charges not covered by medical insurance carrier (s). I authorize payment of medical benefits directly to CNMRI, PA and its physicians on my behalf for services rendered to myself and/or dependent. I further authorize the release of information to any third party payor providing benefits or to its designated utilization review agent for this or a related claim and copies of this authorization to be used in place of the original whether manual or electronic.

_____MEDICARE PATIENTS ASSIGNMENT OF BENEFITS/AUTHORIZATION TO RELEASE INFORMATION: I request that payment of authorized Medicare benefits be made on my behalf to CNMRI, PA and its physicians. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly Healthcare Financing Administration) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature below requests that payment be made and authorizes release of medical information necessary to the pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurance or agency shown. CNMRI, PA accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

_____I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have reviewed my registration and insurance information and certify that it is true and correct to the best of my knowledge. I will notify you of any changes to this information.

_____I have read and understand the CNMRI Payment Policy and agree to abide by its guidelines.

I have read the Pharmacy Benefit Management (PBM) Information:

_____I consent to CNMRI, PA requesting and using my medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

_____I do not consent to CNMRI, PA requesting and using my medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

_____I have received the Notice of Privacy Practices from CNMRI.

_____ _____

Patient Name Responsible Party Name (if applicable)

_____

Patient DOB

_____

Signature of patient or responsible party

_____

Date