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

Guilford Radiology **Middletown Vein and Aesthetic Center**

Consent For Treatment and Release of Information and Acknowledgment

Consent For Treatment: I hereby authorize the physicians of Radiologic Associates of Middletown in charge of my care 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 for the purpose of treatment, including coordinating my continuing care and as otherwise authorized by law, conducting certain healthcare operations.

Financial Agreement: I understand that I am obligated to pay the account of Radiologic Associates of Middletown in accordance with the regular rates and terms of the organization. I owe and agree to pay Radiologic Associates for any and all charges *not* paid by insurance benefits. If my account is not paid, I will pay all court costs, attorney's fees and other costs incurred by Radiologic Associates to collect the balance owed. I also authorize payment directly to Radiologic Associates for services performed.

Assignment Of Insurance Benefits: In consideration for services rendered or to be rendered, I hereby assign to Radiologic Associates all insurance benefits, without limitation, Medicare or Medicaid benefits, to cover such services. In connection with such assignment, Radiologic Associates 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.

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

Signature:_____ **Date:**_____

Signature of Patient or Person Granting Authorization on Behalf of Patient