Patient's Name _____ **MRI Extremity Imaging Location** _____

I have reviewed and understand my patient rights as set forth in the Privacy Notice provided to me by Extremity Imaging Partners, Inc. ("EIP").

Extremity MRI

I consent to the services necessary for the Extremity MRI. I confirm I have been informed of and have participated in the planning of care and services provided by Extremity Imaging Partners, Inc. and sign this Acknowledgement and Consent willingly and voluntarily. I understand that Extremity Imaging Partners, Inc. may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Acknowledgement and Consent.

Notice of Service/Charges

The services Extremity Imaging Partners, Inc. will provide for me are indicated below.

Service	Primary Payer	Expected Patient Financial Responsibility*
		Co-payments, Deductibles, Coinsurance, Lifetime maximums, Charges for non-covered services, as determined by your insurance plan.
		Co-payments, Deductibles, Coinsurance, Lifetime maximums, Charges for non-covered services, as determined by your insurance plan.
		Co-payments, Deductibles, Coinsurance, Lifetime maximums, Charges for non-covered services, as determined by your insurance plan.
		Co-payments, Deductibles, Coinsurance, Lifetime maximums, Charges for non-covered services, as determined by your insurance plan.

* or financially responsible party, if other than patient

I understand that I am responsible to Extremity Imaging Partners, Inc. for any/all charges not paid by a third party including co-payments, deductibles, coinsurance, lifetime maximums, or charges for non-covered services except where program requirements or contractual agreements hold me harmless. I further understand that I will be held liable for payment if I fail to notify Extremity Imaging Partners, Inc. if I disenroll from or become ineligible for coverage under my current plan. **If this presents a financial hardship, or if you have any questions or concerns, please address with your Extremity Imaging Partners, Inc. representative.**

Authorization for Payment

I certify that the information provided by me is correct. I authorize my insurance company(ies) to furnish any agent of Extremity Imaging Partners, Inc. any and all information to my insurance benefits and status of claims submitted by Extremity Imaging Partners, Inc. I authorize payment directly to Extremity Imaging Partners, Inc. or Medicare benefits (as applicable) and other insurance benefits otherwise payable to me. In the event that my insurance carrier does not accept "assignment of benefits", or any other payments are sent directly to me, I will hold them in trust for Extremity Imaging Partners, Inc. for payment of my bill. I understand that I can make payment for services by either personal check or by endorsing the insurance payment by writing "Pay to the order of Extremity Imaging Partners, Inc." and my signature.

Authorization to Release Information

I consent to the release of information and/or disclosure to Extremity Imaging Partners, Inc. of all or any part of my medical record by any physician, hospital, or other facility of which I have been a patient. I consent to checking of my credit and financial rating and history with any person, firm or credit bureau if I may have any self-pay responsibility. I consent to the release of information by Extremity Imaging Partners, Inc. to individuals acting in official capacities as my advocate, representing governmental or third party payers, governmental agencies, accrediting bodies or other health care providers involved in my care including any successors of Extremity Imaging Partners, Inc.

Medicare Beneficiaries **Medicare Identification Number** _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Extremity Imaging Partners, Inc. for any services furnished to me by Extremity Imaging Partners, Inc. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related service.

Medigap Insurer _____ **Medigap Policy Number** _____

I request that payment of authorized Medigap benefits be made either to me or on my behalf to Extremity Imaging Partners, Inc. for any services furnished to me by Extremity Imaging Partners, Inc. I authorize any holder of Medicare information about me to release to the Medigap Insurer any information needed to determine these benefits payable for related services.

Patient *or* Authorized Representative Signature _____ **Date** _____

Patient Name _____ _____

Applicable only if authorized representative signs for patient — Relationship to patient *or* Description of representative's authority to act for patient

EIP Representative _____

Note: This document shall not be valid if altered in any way.

If the patient did not sign, please state the reason including patient's understanding that representative is signing.

_____

_____

For Translation:

☐ This document was translated to patient/authorized representative into _____
Language/Sign Language

☐ This document was read to the patient verbatim/provided on an audio cassette and questions, if any, were answered prior to signature.

Translated by _____ Date _____
Signature/Title