Southeast Medical Imaging Brinton Lake

PATIENT CONSENT – OUTPATIENT

CONSENT FOR OUTPATIENT SERVICES

I consent to examination, routine testing and medical treatment, which my doctor and/or other doctors who care for me believe is necessary. I understand medicine is not an exact science; no guarantees or promises have been made to me about my treatment. I accept that the services provided are given in the least restrictive setting and manner to meet my needs. I understand the doctors who care for me may not be employees Southeast Medical Imaging. These doctors may be independent contractors who have staff privileges and have agreed to provide care to hospital patients. If special procedures are needed, I will be asked by my doctor to give separate informed consent. I have the right to refuse any drugs, treatment or procedures. I understand that neither Southeast Medical Imaging nor my doctor is responsible for my personal belongings during my care. I have read and understand this consent for care and my questions have been answered. My signature means I agree to the above. I can ask for a copy of this form.

PATIENT/AUTHORIZED PARTY	DATE	PRINT NAME	DATE
RELATIONSHIP TO PATIENT	DATE	WITNESS NAME & INITIALS	DATE

ASSIGNMENT OF HEALTH INSURANCE BENEFITS AND AGREEMENT FOR FINANCIAL RESPONSIBILITY

I authorize payment to my doctors and/or Southeast Medical Imaging of any health insurance benefits that are payable to me, including Medicare and/or Medicaid payments, Medigap payments, and/or payments under any Employer Self-Funded Medical Expense Reimbursement Plan as governed by the Employee Retirement Income Security Act (ERISA), and/or payments from private insurance companies. I certify that the information that I gave to my doctors and/or Southeast Medical Imaging to bill for payment is correct. I assign and transfer to Southeast Medical Imaging, my doctors and/or hospital or their agents the right to act in my place to bill and collect all payments that are payable to me under any private or government plan of health benefits and/or to sue any insurer or other responsible party to obtain these payments. These payments may not be more than the balance due my doctors and/or Southeast Medical Imaging and I understand that I have to pay my doctors and/or Southeast Medical Imaging for all charges not paid by my health insurance. This payment authorization, assignment of benefits and agreement for financial responsibility is also binding on my administrators, executors, heirs and successors. I understand Southeast Medical Imaging will bill me for care given by Southeast Medical Imaging employees. I have read this assignment of benefits; I understand this assignment of benefits, and my questions have been answered.

PATIENT/AUTHORIZED PARTY	WITNESS INITIALS

AUTHORIZATION TO RELEASE INFORMATION FOR TREATMENT, PAYMENT OR OPERATIONS

I understand Southeast Medical Imaging and/or my doctor is allowed to use and disclose my health information for treatment, payment, or operations and 1 understand Southeast Medical Imaging and/or my doctor releases this information as allowed by law.
I understand that when Southeast Medical Imaging uses and discloses my health information as described in this authorization, the doctor and/or Southeast Medical Imaging may disclose general information contained within my medical record. I understand that full disclosure of my HIV, drug and alcohol abuse or mental health treatment record will not occur without my specific written consent relating to these conditions. My signature below means that I have read this authorization and I understand this authorization to release my health information.

PATIENT/AUTHORIZED PARTY	WITNESS INITIALS

VERBAL CONSENT

If consent from the patient is verbal because of the patient's physical inability to sign this consent form, then please check this box and have a staff member sign as a witness above and a second witness sign here

SECOND WITNESS' NAME

NOTICE OF PRIVACY PRACTICES

My signature below means that I was given Southeast Medical Imaging's Notice of Privacy Practices, which explains in more detail **some** of the uses
and disclosures of my health information.

PATIENT/AUTHORIZED PARTY

REVISED 10/03/2005