

# GAINESVILLE OPEN MRI

## CONSENT, INFORMATION RELEASE, DIRECTIVE OF PAYMENT & IRREVOCABLE LIEN

**Medical Consent** - I consent to the examination, treatment and procedures which may be performed during this visit; including emergency treatment considered necessary by patient's physician(s).

**Release of Information** - I hereby authorize the above named provider to release any information needed to process the claims in reference to the examination, treatment, or procedures rendered by the provider. I further permit a copy of this authorization to be used in place of the original.

**Financial Responsibility** - I understand that payment is due in full at the time of service and if not, I acknowledge that I am responsible to make the appropriate financial arrangements including but not limited to insurance benefits. Should my account become delinquent or be referred to any third party for collection efforts, I agree to pay all reasonable interest, attorney fees, court costs and/or collection expenses.

**Medicare/Medicaid Benefits Only** - If applicable, I certify that the information given by me in applying for release under Title XVIII and/or XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed to this or a related Medicare/Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to Gainesville Open MRI. I authorize the above named provider to submit to Medicare and/or Medicaid for payment on my behalf.

**Irrevocable Patient-Attorney-Healthcare Provider Lien (liability cases only)** – I authorize and direct my attorney to pay the above named provider directly any sums due for medical services rendered to me. I direct my attorney to withhold such funds from any settlement, verdict or judgment that is rendered in my case. I hereby notify my attorney that I am giving the above named provider a lien on these benefits or settlement proceeds. In consideration for the above named provider waiting for payment, this lien is irrevocable and can only be satisfied by full payment of all sums due for medical services rendered. I authorize the above named provider to notify my attorney of this lien at the provider's discretion. I understand that any settlement, verdict or judgment proceeds cannot be disbursed to me without first satisfying this lien. Should a dispute arise regarding payment of my charges, I authorize and direct my attorney to hold all monies sufficient to satisfy this lien in escrow until the dispute can be resolved. I further understand that it would be a violation of my attorney's ethical duties to disburse these disputed funds prior to resolution to the lien dispute.

Patient Name (Please Print) \_\_\_\_\_ Date \_\_\_\_\_

Patient Signature \_\_\_\_\_

I, \_\_\_\_\_, have been informed of the Notice of Patient Privacy Practices made available by Gainesville Open MRI, Inc.

Patient Name (Please Print) \_\_\_\_\_ Date \_\_\_\_\_