GAINESVILLE HIGH FIELD MRI

MEDICAL CONSENT: I consent to the examination, treatment, and procedures, which may be performed during the visit, including emergency treatment, considered necessary by my physician.

RELEASE INFORMATION: I 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. I authorize the above named provider to request any information/records from other medical providers needed to help the process of my medical claim with Gainesville High Field MRI.

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 facilitating my insurance benefits and/or making monthly payment arrangements. Should my account become delinquent or be referred to any third party collection efforts, I agree to pay all reasonable interest, attorney fees, court costs and/or collection expenses. I agree in order for Gainesville High Field MRI to collect any amounts I may owe, they may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could results in charges to me.

MEDICARE/MEDICAID BENEFITS ONLY: If applicable, I certify that the information given by me in applying for payment 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 High Field 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 and sums dues 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 be satisfied by full payment of all sums dues 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 or my attorney's ethical duties to disburse these disputed funds prior to resolution to the lien dispute.

I have read this disclosure and I agree to the terms described above.

Patient Name (please print): _____ Date: _____

Patient Signature: _____

I, _____, have been informed of the Notice of Patient Privacy Practices made available by Gainesville High Field MRI.

Patient Signature: _____ Date: _____