



Consultants in Radiology P.A.

Turning images into answers

CONSENT TO TREAT

I hereby authorize such medical procedures as deemed necessary to be performed on the patient named below by or at the direction of the physicians of Consultants in Radiology, P.A. (CIRPA).

Financial Responsibility

I acknowledge that my insurance coverage, if any, is a contract between me and my insurance carrier. CIRPA may, as a courtesy, file insurance claims on my behalf. I hereby accept full responsibility for payment of all charges for services rendered by CIRPA regardless of the status of any claims filed or payment decisions by my insurance carrier(s).

Assignment of Insurance Benefits and Release of Medical Information

I hereby assign, transfer and set over to CIRPA all of my rights, title and interest to my medical reimbursement benefits under insurance policies which may be in effect now or in the future. These rights are limited to unpaid charges for services provided by CIRPA. I understand and agree that original films and medical records are the property of CIRPA. I authorize CIRPA to release any medical information to any insurance carrier which is necessary to process a claim. I further authorize CIRPA to furnish a copy, by any means (ex. telephone, facsimile, written, oral, etc.), of any medical records regarding the patient to: (1) the physician who referred the patient to CIRPA or (2) and other physician that represents, either orally or in writing, to CIRPA that he is rendering medical services to the patient. I also hereby authorize CIRPA to request from any other medical facility, by any means (ex. telephone, facsimile, written, oral, etc.), medical information and/or films of previous imaging procedures to aid in diagnosis and treatment.

I request that payment of authorized Medicare benefits be made either to me or on my behalf to CIRPA for any services furnished me by its physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services.

Signature on File

I acknowledge that I have read and agree to be bound by the terms stated above. All authorizations granted herein shall be valid and remain in effect until revoked by me in writing and delivered by me to CIRPA.

Please complete all information in this shaded area

Signature _____ Date _____

Patient Name _____

Social Security Number _____ Date of Birth _____

For office use only: Account Number _____