



6590 Powers Ferry Rd, Atlanta, GA 30339 Phone: (770) 953-0106 Fax: (770) 953-0109

Date: _____

Registration & Authorization to Treat

Patient's Legal Name

Last:

First:

Middle:

Please read and sign the following treatment agreement so that we may proceed with your care and treatment.

MEDICAL TREATMENT PERMIT: I do hereby consent to **Medica Stand-Up MRI of Atlanta** to perform a(n) **MR**, as ordered by a licensed practicing physician.

AUTHORIZATION TO UTILIZE RESULTS AND RELEASE OF INFORMATION: I hereby authorize the use and release of any medical information, including diagnostic imaging studies, necessary to process insurance claims including workmen's compensation or any medical information that is required for any health care related utilization review or quality assurance activities. I also authorize the release of any medical information to my physician, if requested.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE: I hereby acknowledge that Medica made available to me a copy of the Notice of Privacy concerning how the use or disclosure of Protected Health Information will be handled by the facility.

AUTHORIZATION TO CONTACT ME: I authorize Medica to contact me, either by phone or by mail to provide a reminder of an appointment, and/or information about any new technology or new services the Medica Facility will be offering.

____ Yes or ____ No

ASSIGNMENT OF BENEFITS AND RIGHTS OF RECOVERY: I hereby assign and authorize payment to **Medica Stand-Up MRI of Atlanta** of all medical benefits, including major medical benefits, to which I am entitled to under any insurance policy or policies, under any self-insurance program, or under any other benefit plan.

I understand that it is my obligation to know my Payor's requirements and ensure that they have been fulfilled.

I understand and agree that I am financially responsible for any charges not covered by this assignment and agree to pay Medica the full balance that is not reimbursed by my medical provider benefits (certain regulations and exceptions apply for Medicaid and Medicare Beneficiaries).

NOTE: If you did not provide your insurance information today, or if it is not accurate, then you may be obligated to make full payment of all charges. It will be your responsibility to file the claim with your insurance provider. If you provided us insurance information today, you are obligated to pay all co-payments, deductibles, and any non-covered out-of-network/reduced benefits at the time the services are rendered. You have an affirmative duty to make sure that payment and/or correct information for payment is given to Medica for reimbursement of services provided.

Be advised there will be a fee of \$30 for any returned check. Should your account reach collection status, there will be a surcharge added equal to 35% of the unpaid balance.

Patient Name

Patient's Signature

Date