GENERAL AUTHORIZATION AND ASSIGNMENT FOR SERVICES **MRN: _____**

AUTHORIZATION FOR ROUTINE DIAGNOSTIC PROCEDURES: The undersigned consents to medical care, as may be deemed necessary or advisable in the judgment of my physicians or other providers. Such medical treatment may be performed at any NeuroSkeletal Imaging (NSI) facility, including emergency treatment or services, and may include, but not limited to diagnostic procedures

I have been advised payment is due at service. I understand that I will receive itemized statements of my account reflecting the balance pending with insurance and due from me. It remains my responsibility for final payment on my account, regardless of the payment, or lack of payment by my insurance carrier. I accept these arrangements while continuing to receive care and services from NSI.

This authorization and assignment is to be a continuing one, remaining in force until revoked in writing by the undersigned.

PATIENT NAME: (PRINTED):_____DOB: _____

PATIENT'S SIGNATURE (REQUIRED): _____DATE: _____
(Parent/Trustee/Guardian if patient is a minor) I agree to the above.

LEGAL SIGNATURE (REQUIRED): _____DATE: _____
Parent/Trustee /Guardian if patient is a Minor or unable to sign. I agree to pay if patient doesn't pay.

Please Initial the appropriate Authorization(s)

Initial

MEDICARE B SIGNATURE AUTHORIZATION: For services beginning today, I authorize my holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare & Medicaid Services or its intermediaries or carriers, or the billing agent of NeuroSkeletal Imaging (NSI), any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment.

Initial

HEALTH INSURANCE AUTHORIZATION: I assign the benefits payable for physician services to the NeuroSkeletal Imaging (NSI) physician and organization furnishing the services and authorize NSI to submit a claim to my health insurance carrier as needed for payment to the physician or me. I authorize any holder of medical or other information about me to release to my insurance carrier any information needed for this or a related claim. A copy of this authorization may be used in lieu of the original.

Initial

AUTO / WORK COMP INSURANCE AUTHORIZATION: I hereby authorize, direct and demand that my personal injury protection insurance pay directly to my assignee: **NeuroSkeletal Imaging LLC** such sums as may be due and owing in this Office for service rendered to me, both by reason of accident or illness and by reason of any other bills that are due this Office, and to withhold such sums from any disability benefits, medical payment benefits, No-Fault benefits, health and accident benefits, workmen=s compensation benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said Office. I hereby further give a lien to said Office against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by said Office. This is to act as an assignment of all my rights, benefits and privileges under my insurance policy to my assignee for any and all amounts owed.

I hereby assign and transfer to this my assignee/health care provider any and all causes of action that I may have or that might exist in my favor against my insurance company and authorize this Office to prosecute said cause of action either in my name or in the Office's name, and further I authorize this Office to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

I authorize the Office to release pursuant to Privacy Rule, 45C.F.R. parts 160 and 164 promulgated pursuant to the HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (AHIPPA@), Pub. L. No. 104-191, 110 Stat. 1936 (1996), any information including, but not limited to, medical records, insurance information or documents otherwise pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment.

Initial

ADDITIONAL INFORMATION:

1. **NOTICE OF HEALTHCARE INFORMATION:** All patient records remain the property of NSI. Records are centralized and may be accessed by any NSI medical provider, or NSI employee, as a necessary function of their role within our organization. NSI does not release Patient Records unless necessary for payment, treatment or operations, or if the patient has signed a request to transfer the medical records. Any non-NSI records that are included in the NSI chart will be considered a permanent part of the patient record. At this time, NSI does not use e-mail as an official means of healthcare communication. If you email your physician, there is no guarantee your email will be responded to in a timely manner.

2. **HIPAA:** NSI complies with all HIPAA and other federal privacy regulations. A notice of NSI privacy policies is available upon request. I acknowledge, by my signature above, that I have been made aware of my right to review or obtain a copy of the policies.

3. **RELEASE OF MEDICAL INFORMATION**: Permission to pick up films/report on my behalf is given to:

_____