

COOL SPRINGS IMAGING

PATIENT WAIVER

I HEREBY AUTHORIZE AND CONSENT TO THE RADIOLOGY PROCEDURES ORDERED BY MY PHYSICIAN AND PERFORMED AT COOL SPRINGS IMAGING. I ALSO UNDERSTAND THAT THE PROCEDURE MAY REQUIRE THE USE OF IV OR ORAL CONTRAST MATERIALS AND TO MY KNOWLEDGE I HAVE NO PAST CONTRAINDICATIONS TO CONTRAST MATERIAL.

AS A SERVICE TO YOU, WE ARE HAPPY TO FILE THE CLAIM FOR INSURANCE ON YOUR BEHALF, HOWEVER WE REQUEST THE FOLLOWING FROM YOU:

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO PROCESS INSURANCE CLAIMS FOR OFFICE RELATED CHARGES. IN ADDITION I DIRECT AND AUTHORIZE PAYMENT TO COOL SPRINGS IMAGING, IN THE EVENT THE INSURANCE IS FILED.

IF THIS IS A LIABILITY CLAIM I AUTHORIZE AND REQUEST THAT THE INSURANCE COMPANY AND/OR THE ATTORNEY PAY COOL SPRINGS IMAGING DIRECTLY FROM ANY SETTLEMENTS DUE ME.

I ACCEPT LEGAL RESPONSIBILITY FOR ANY CHARGES AND I AGREE TO PAY ANY LEGAL/COLLECTION EXPENSES SHOULD MY ACCOUNT BECOME DELINQUENT OR BE PLACED WITH AN OUTSIDE COLLECTION AGENCY OR ATTORNEY.

EMERGENCY CONTACT/NEXT OF KIN _____

PHONE NUMBER _____

PATIENT'S / GUARDIAN'S SIGNATURE

DATE