Professional Imaging

ASSIGNMENT OF BENEFITS

I hereby request that payment of insurance benefits be made directly to Professional Imaging, on my behalf for any services provided to me. I acknowledge and understand that I am financially responsible for all charges relating to the service(s) rendered to my dependent to me. If, for any reason my insurance carrier does not pay any portion of my bill, I agree to make arrangements for prompt payment of my bill.

CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION

PLEASE CIRCLE ONE

YES NO I have received the Notice of Privacy Practices and am aware of the following:

1. I have the right to place restrictions on the way my Protected Health Information (PHI) is used or disclosed. Professional Imaging is not required to agree with my requested restrictions. Once Professional Imaging agrees to my restrictions, it will comply with those restrictions.
2. I have a right to revoke my consent for the use and disclosure of my protected health information at any time. I understand that, if I choose to revoke my consent, I will submit a written statement to Professional Imaging that is signed by me. Upon receipt, Professional Imaging will immediately comply with my request to revoke consent, expect to the extent that is has already taken some action that was based on my original consent.
3. Professional Imaging has reserved the right to change from time to time its privacy practices that are described in its Notice of Privacy Practices. Whenever its privacy practices are changed, Professional Imaging will modify the Notice accordingly.
4. The Notice of Privacy Practices and Professional Imaging policies and procedures are based on the Healthcare Insurance Portability & Accountability Act of 1996 as amended periodically.

YES NO I hereby authorize Professional Imaging, to release Protected Health Information (PHI) contained in

my medical records to my treating physician, insurance company, attorney, and immediate family behalf of myself and/ or dependents for the purpose of Treatment, Payment and Operations (TPO)

Signed: _____ Date: _____

Patient Name (if different than the above signed): _____

May we release patient's medical reports/images with members of your family, friends, and other physicians who may contact the office regarding the patient?

(YES) (NO)

IF YES: NAME OF PERSON/PHYSICIAN	**RELATIONSHIP TO PATIENT**
_____	_____
_____	_____