SOUTH JERSEY RADIOLOGY ASSOCIATES

Consent for Treatment

The undersigned hereby consents to any medical services rendered to the patient by the physicians, employees and contracted healthcare providers of South Jersey Radiology Associates, P.A.

Authorization to Release Information

The undersigned authorizes South Jersey Radiology Associates, P.A. (SJRA) to release all or any part of the medical record of the patient named on this encounter form to other healthcare providers, providers, insurance companies, organization, or agencies as may be concerned with the diagnosis, treatment or payment of the medical services rendered. The undersigned also authorizes other healthcare providers to release all or any part of the medical record of the patient named on this encounter form to SJRA that may be required to assist SJRA in patient's diagnosis and/or treatment.

Assignment of Insurance Benefits

As a convenience to our patients, South Jersey Radiology Associates, P.A. will bill your insurance carrier directly. I hereby assign, transfer and set over to South Jersey Radiology Associates, P.A. all of the rights, title and interest to medical, automobile personal injury protection, or workers compensation medical insurance benefits, and all other rights and privileges otherwise payable to me for those services provided. I also, understand that obtaining precertification, authorization or other requirements or conditions of my insurance coverage is my responsibility.

HIPAA Privacy Policy

The undersigned acknowledges that he/she has received a copy of Patient Rights as required by the State of NJ and SJRA's Notice of Privacy Policy as required by HIPAA.

Financial Responsibility

Payment is required at the time of service. Any payment collected today represents an estimate of the cost share for your study. Your final balance due, will be determined by your insurance company after it has processed your claim. The undersigned agrees, whether signing as the patient or an agent, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to be responsible for all or any unpaid portion of the bill incurred. I further understand the unpaid portion of the bill may be insurance deductible, coinsurance, copayments or the entire bill, if my insurance carrier denies coverage.

The undersigned certifies that he/she has read the foregoing and understands its terms and is the patient or is a duly authorized representative of the patient and accepts the above terms.

X _____ _____

Signature of patient / authorized representative Date

_____ _____

Witness Date