SOUTH JERSEY RADIOLOGY ASSOCIATES

Consent for Treatment

I hereby consent to any medical services rendered by the physicians, employees and contracted healthcare providers of South Jersey Radiology Associates, P.A.

Health Care Communications

I understand SJRA may contact me by email and/or text messaging to remind me of my appointment, to obtain feedback on my experience with the healthcare team, and to provide general health care information. I consent to receiving appointment reminders and other health care communications at the email address and/or cell phone number that I have provided to SJRA. Standard messaging and data rates may apply.

Assignment of Insurance Benefits

I understand, South Jersey Radiology Associates, P.A. will bill my 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 meeting other requirements or conditions of my insurance coverage is my responsibility.

HIPAA and Patient Rights

I acknowledge, I have been offered a copy of SJRA's 'Notice of Privacy Policy', as required by HIPAA, and a copy of 'SJRA's Patient Rights', as required by the New Jersey Department of Health.

Patient Received ☐ Patient Declined ☐

Financial Responsibility

I understand payment is required at the time of service. Any payment collected today represents an estimate of the cost share for my study. My final balance due, will be determined by my insurance company after it has processed my claim. I agree to be responsible for all or any unpaid portion of the bill incurred, which may be insurance deductible, coinsurance, copayments or the entire bill, if my insurance carrier denies coverage.

I certify I have read the foregoing and understand its terms, and as the patient or as a duly authorized representative of the patient, I accept the above terms.

X____ ________________

Signature of patient / authorized representative Date

____

Print name

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Relationship to patient (if authorized representative)

____ ________________

Witness Date

FOR INTERNAL SJRA USE ONLY