CASTRO VALLEY
OPEN MRI

Consent for Treatment and Financial Agreement

A. **Consent for Treatment**: I am entering Castro Valley Open MRI for the purpose of medical and /or invasive treatment or diagnosis. I consent to my physician, consulting and/or referring physicians and their assistants and designees, and other facility personnel, to provide me with medical, diagnostic, or other treatment services judged necessary and/or appropriate by my physician. This includes my consent for such services as x-rays and laboratory tests, treatments or medication, monitoring and all other procedures or treatments that do not required my specific informed consent.

B. **General Acknowledgment**: I understand the practice of medicine is not an exact science. I understand that medical treatment and diagnosis may involve risk of injury. No guarantees have been made to me in the relations to the results of my examination's or treatments in the facility. I understand that it is my responsibility to follow instructions and make arrangements for follow-up care. I understand that I may review and obtain a copy of my medical records at my own expense, and that this review shall take place in the facility, during regular business hours.

C. **Assignment and Agreement to Pay**: I understand that I am responsible for payment for the services that I receive and guarantee payment for these services. I hereby assign to the facility and the physicians and professionals associated with the facility, for application to my bill for services all rights and claim for reimbursement under federal or state healthcare plan (including but not limited to Medicare or Medicaid), insurance policy, and managed care arrangement or any other similar third party payer arrangement that covers health care cost and for which payment may be available to cover that cost of the services provided me. I understand that I am responsible for any applicable co-payment, deductible, co-insurance and/or non-covered cost and charges at the time of my MRI services. I understand that not all insurance companies pay the usual and customary fees of the facility, the physician and/or the professionals associated with the facility. Therefore, when permitted by law and any outstanding balance will be my responsibility. I understand and agree that I am responsible for the cost of collection and/or reasonable attorney fees related to my account. I understand that my health information will be released to my insurers, payers, or other for billing purposes.

D. **Privacy Notice**: I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

   a. Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
   b. Obtain payment from third party payers.
   c. Conduct normal healthcare operations such as quality assessments and physician certification.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact the facility at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you agree then you are bond to abide by such restriction.

Patient Signature: _____ Date: _____/ _____/ 2013