Cedar Court Imaging (CCI)
1200 Cedar Court
Carbondale, IL 62901
(618) 529-8500

Patient Name:_____ Date of Service:_____
Social Security Number:_____ (optional)

AUTHORIZATION FOR TREATMENT AND FINANCIAL RESPONSIBILITY

Consent for Treatment:
Your doctor has scheduled for you a diagnostic study (MRI, CT, Ultrasound, Bone Density, X-Ray,). Any questions regarding this test will be answered by the Cedar Court Imaging staff to the best of their ability:

I give my consent for the staff at CCI to perform the examination requested by my referring physician. I understand that CCI's radiologist will interpret the results of the exams performed at Cedar Court Imaging in a timely manner, and forward results to my physician.

Financial Responsibility:
Although most insurance reimburse for diagnostic studies, some reimburse only partially. In the event services provided by Cedar Court Imaging are deemed "not medically necessary", or are not covered by Medicare, Medicaid or any other insurance carrier, including workers compensation or liability claims, I understand I am financially responsible for charges incurred. I understand I am responsible for any health insurance deductibles and/or co-payments that may apply under my particular insurance plan.

Medicare Insurance Benefits:
I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the release of medical or other information to the Social Security Administration or its intermediaries or carriers concerning this or a related Medicare claim filed by Cedar Court Imaging. I request that payment of authorized benefits be made on my behalf.

Assignment of Other Insurance Benefits:
In consideration of any and all medical services, care, drugs, supplies, and equipment provided or furnished by Cedar Court Imaging. I authorize direct payment to Cedar Court Imaging of all insurance benefits applicable to this date of service, which are now or which shall become due and payable to me. I hereby authorize direct payment to Cedar Court Imaging of all insurance benefits applicable to diagnostic and /or medical services rendered by Cedar Court Imaging or its staff.

Storage and Release of Information/HIPAA Compliance:
I consent to the electronic storage and transmission of patient information, including medical information in accordance with the federal **Health Insurance and Portability Act (HIPAA).** I further understand that upon request, I will receive a copy of CCI's HIPAA compliance statement as well as a brochure explaining my rights under the HIPAA regulations. I authorize my employer and/or insurance company to release medical and/or insurance information, requested by Cedar Court Imaging. I also authorize Cedar Court Imaging to release any information to any health professional, including by not limited to my referring physician providing service, or to the patient's insurance company or any other third party-payor as needed to secure and guarantee payment for services. These may also include governmental or other entities as required by law for purposes of reporting, or for purposes of determining eligibility in government sponsored benefit programs. **I give Cedar Court Imaging written authorization to obtain any and all medical records, ie.; films, reports, etc. that they deem necessary in order to facilitate the continuity of my care.**

By signing below, I acknowledge that I have read and fully understand this form and agree to the information contained above.

_____ _____
Signature of Patient or person authorized Date

_____ _____
Witness Date