CRA MEDICAL IMAGING

Medical Imaging Center
Crouse Medical Imaging Services
Diagnostic Imaging Center

PATIENT CONSENT

Patient Name_____

Date of Birth_____ Social Security #_____

Address _____
Street City State Zip Code

Email Address _____ **(used for patient portal access)**

Phone Numbers: *Please check box for preferred contact

☐ Cell ( ) _____
☐ Home ( ) _____

AUTHORIZATION FOR MEDICAL TREATMENT: I hereby authorize the physicians, nurses, and allied health professional staff at Medical Imaging Center, LLP to provide medical treatment to me or the patient designated below. I agree to diagnostic tests and procedures and acknowledge that no guarantees or assurances have been made to me concerning the results or findings intended from treatment or examination at Medical Imaging Center, LLP.

RELEASE OF MEDICAL INFORMATION FOR BILLING: I hereby authorize and direct Medical Imaging Center, LLP to release such medical information as is necessary to complete forms for continued care, payment by insurance carriers, health care plans and third party payors.

ASSIGNMENT OF BENEFITS, GUARANTEE OF PAYMENT AND CHARITY CARE NOTICE:
I hereby authorize and direct my insurance carrier and/or health care plan to make payment to Medical Imaging Center, LLP and hereby assign Medical Imaging Center, LLP all rights, title and interest I have in insurance proceeds or benefits payable to me or in my behalf for services rendered to me by Medical Imaging Center, LLP. I acknowledge that as a member of a health care plan, I may be responsible to notify my primary care physician or obtain pre-authorization for services. I understand that I am financially responsible to Medical Imaging Center, LLP for all charges, including those not paid by insurers or health care plans for services not authorized as specified in my benefit package, incurred by me or in my behalf. However, if treatment has been given in accordance with New York State's No-Fault Law, it is understood that my liability is limited to charges authorized under such law and applicable New York State No-Fault Fee Schedules.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: By signing below, I acknowledge receipt of the Notice of Privacy Practices in hard copy or online version which outlines how health information about me may be used or disclosed. These practices are in compliance with the HIPAA Privacy Rule (Health Insurance Portability and Accountability Act) and include the Omnibus Final Rule standards.

SEE OTHER SIDE

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION: I hereby authorize and direct Medical Imaging Center, LLP to release medical information and/or prior medical imaging exams and reports for the purpose of continuity of care to physicians and/or medical facilities. I also authorize Medical Imaging Center, LLP to obtain medical information and/or prior medical imaging exams and reports for the purpose of continuity of care.

DISCLOSURE OF PHI TO DESIGNATED INDIVIDUALS: Our Practice may disclose to a family member, other relative or any other person identified by you ("designated individual") your protected health information (PHI) directly relevant to that person's involvement with your care or the payment for your care. Our Practice may also use or disclose your PHI to notify or assist in notifying (including identifying or locating) the designated individual, your personal representative, or another person responsible for your care, of your location, general condition or death. However, this can only occur if you agree to a disclosure of such persons.

NO SHOW POLICY: It is the policy of CRA Medical Imaging (CRA) to monitor and manage no-shows and cancellations of scheduled appointments. Any patient who fails to arrive for a scheduled appointment without canceling the appointment within 24 hours before the scheduled time is considered a "no-show" patient. A no-show patient is charged a $50 fee as established by the CRA management team for failure to show up and will be reported to the patient's referring physician. This fee may be required to be paid before scheduling further appointments. For the full no-show policy, please visit craimaging.com.

If you wish to agree to such disclosures, **please designate the family member, other relative, or any other person you wish to be your Designated Individual(s) to obtain information on your behalf:**

Name	Relationship to patient	Phone number
Name	Relationship to patient	Phone number

Patient Name

Signature Date

Printed Name of Legal Authorized Representative