**CAHABA VALLEY IMAGING PHONE: 205-620-3830 FAX 205-620-3831**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_APT #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Contract Holder:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Assignment of Benefits:** The undersigned assigns to and authorizes the benefits payable for radiological services to Shades Mountain Imaging, North Jefferson Imaging or Cahaba Valley Imaging.

**Authorization to assign Benefits and Release information to Medicare/Medicaid:** I certify the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries any information needed for this or other related Medicare claims. I request the payment of authorized benefits be made on my behalf to Shades Mountain Imaging, North Jefferson Imaging or Cahaba Valley Imaging**.**

**Financial Responsibility:** The undersigned is agreeable and understands that Shades Mountain Imaging, North Jefferson Imaging or Cahaba Valley Imaging charges which are not paid may be placed with a collection agency and that will be responsible for the payment of the amount due including collection fees and attorney fees.

I understand that my insurance company may consider the procedure to be a non-covered service and may not pay for this procedure. Therefore, I agree to assume the financial responsibility for this medical care and to pay the full charge of the services. I also agree to waive all personal property exemptions, of any kind, in all states that may be available to me.

**Patient Consent Agreement:** I understand that as a part of my healthcare, Shades Mountain Imaging, North Jefferson Imaging or Cahaba Valley Imaging originates and maintains health records describing my health history, symptoms, examination, test results, diagnosis, treatment, and plans for future care or treatment. I understand this information serves as basis for my treatment and diagnosis, a means of communication among other health professionals who contribute to my care, and a source of information for payment requirements for medical insurance companies. I authorize Shades Mountain Imaging, North Jefferson Imaging and/or Cahaba Valley Imaging to release medical or other personal information orally, written or electronically which may be necessary for the completion of insurance forms, payment of services, further treatment or receipt of benefits.

**Notice of Practices:** I have been provided with a copy of Notice of Privacy Practices concerning the use and disclosure of my Protected Health Information will be handled by this practice.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_