AUTHORIZATION AND AGREEMENTS
PALM HARBOR MRI
32615 US HWY 19 N. STE #4
PALM HARBOR, FL 34684
Phone: 727-787-6900
Fax: 727-787-1892

Patient Name:

The undersigned hereby makes the following acknowledgement and agreement regarding the MRI/MRA/CT/Ultrasound/X-Ray/Mammography and Professional services to be provided to the patient whose name appears above.

CONSENT FOR MRI/MRA/CT/ULTRASOUND/X-RAY/MAMMOGRAPHY TECHNICAL/PROFESSIONAL SERVICES

I understand that services rendered are necessary for the patient by the above companies and its physicians. I hereby consent to and authorize the administration of the MRI/MRA/CT/Ultrasound/X-Ray/Mammography study that may be considered advisable or necessary in the judgment of the referring physician. I authorize any medical records may be obtained by the above companies.

ENHANCEMENT CONSENT

Your doctor may order an image enhancement agent to be used for your MRI/MRA/CT/Ultrasound/X-Ray/Mammography. This agent helps make the details of the MRI/MRA/CT/Ultrasound/X-Ray/Mammography clearer and does not mean your condition is more serious or that there is anything additionally wrong with you. We are asking your consent to use the enhancement only if your doctor has requested this use, or if it is deemed medically necessary.

AGREEMENT TO PAY FOR SERVICES

For and in consideration of the services provided to the patient, I promise to pay the above companies for all charges and services rendered to or in behalf of the patient. The above companies may secure any credit information that may be necessary. I also understand that I may be insured through a PPO/HMO pan and that it is my responsibility to obtain the proper and necessary referrals from my primary care physician before services are rendered. The above companies shall make all reasonable efforts to assure that the insure is covered by the plan, but ultimately I understand that it is my responsibility.

DIRECT PAYMENT AUTHORIZATION

By way of original or copy hereof, the undersigned patient hereby directs the applicable personal injury protection or medical payments insurance carrier to make payment directly to the above companies. If payment is made out the companies they have the authorizations to endorse the payment with the patient's signature along with its own.

RELEASE OF INFORMATION

I hereby authorize the above companies to release any information in the course of my treatment to my insurance company or any physician needing this information for treatment.

COLLECTION OF ACCOUNT

I understand that if this account is assigned to an attorney for collection and/or suit, the above companies shall be entitled to reasonable attorney's fees and cost of collection. I also understand that if any bad check is written, I am to pay only by cash, money order or credit card to redeem that check and if added cost is incurred to the above company, I agree to pay.

Signature of Patient/Responsible Party **Date**