OREGON ADVANCED IMAGING

AUTHORIZATION FOR CONSENT, RELEASE OF INFORMATION, AND ASSIGNMENT OF BENEFITS

As a courtesy, Oregon Advanced Imaging (OAI) will bill my insurance company. It is my responsibility to supply OAI with accurate, correct insurance information.

I hereby assign to Oregon Advanced Imaging, those benefits otherwise payable to me by any third party as reimbursement of expenses and fees in connection with treatment rendered. I request that payment of authorized benefits be made directly to the medical provider named above on my behalf. I am responsible for any uncovered or unpaid balance owing regardless of assignment. These charges could include amounts applied to my annual deductible or co-payment amounts.

I understand and agree that OAI may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care

If my insurance is Medicare, I certify that the information given by me in applying for payment under title XVIII (Medicare) is correct.

As a courtesy to you, we will bill both our portion of the bill as well as Medford Radiological Group's reading fee; you should plan to receive one bill for both services.

I understand that based on my medical history or age, I may be required to have a lab study completed prior to my exam today. My insurance company will be billed the nominal charge for the on-site test.

I hereby authorize release of my films and/or medical records as needed for subsequent medical care. In the event of positive findings, I authorize my attending physician to release the results of my biopsy-surgery to Oregon Advanced Imaging for their records.

I acknowledge and agree that I have read and approved the information above, and have been offered a copy of Oregon Advanced Imaging's Notice of Privacy Practices.

Signature: _____ Date: _____

If someone other than the patient is signing this authorization, please state relationship with patient and the reason patient is unable to sign.

Patient's legal representative (if applicable): _____ Date: _____

Print name of legal representative: _____ Relationship to patient: _____