
CONSENT TO PROCEDURES

The undersigned consents to the imaging procedures and/or the examination(s) requested by the patient's physician. The undersigned acknowledges that these services have been adequately explained, and that all questions have been answered.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign payment directly to Valley Radiology Consultants Medical Group, Inc. of the insurance benefits to which I may be entitled. Requested information may be released to the insurance carrier.

NOTICE TO MANAGED CARE PATIENTS

Managed care insurances generally require that a representative, often a Primary Care Physician, authorize diagnostic procedures before the plan will accept financial responsibility. Your signature below indicates that you agree to be responsible for payment if you receive services that are not authorized as required by your plan.

MEDICARE PATIENTS

Medicare Authorization (for signature on file): I authorize the release of any medical information necessary to process this claim. I also request payment of government benefits to the party who accepts assignment (Valley Radiology Consultants Medical Group, Inc.).

Signed: _____

Date: _____

Print Name: _____

If not signed by the patient, please include:

Relationship:

parent or guardian of minor patient

guardian or conservator of incompetent patient

Name of Patient: _____

IF YOU WOULD LIKE A COPY OF THIS DOCUMENT, PLEASE INFORM THE STAFF.
