PET/CT Imaging Center
of Northwest Florida

CONSENT FOR SERVICE AND NOTICE OF PRIVACY PRACTICES

RELEASE OF MEDICAL INFORMATION: I acknowledge that records concerning my PET/CT scan are the property of the PET/CT Imaging Center of Northwest Florida. I authorize the PET/CT Imaging Center of NW FL to disclose all or any part of my patient record to the referring physician, my primary care physician, and/or any consulting physician of my choice. I may request the complete privacy practices statement of the PET/CT Imaging Center of NW FL at any time.

ASSIGNMENT OF INSURANCE BENEFITS: I assign payment of all insurance benefits for this PET/CT scan to be made directly to the PET/CT Imaging Center of NW FL.

FINANCIAL AGREEMENT: For and in consideration of services rendered, I agree to pay the PET/CT Imaging Center of NW FL for all charges not covered by insurance payments as statements are rendered. Further, should it become necessary to enforce collection of any unpaid balance for services rendered, I agree to pay all collection and legal expenses incurred by the center including reasonable attorney's fees.

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER: I request payment of authorized Medicare benefits be made on my behalf to the PET/CT Imaging Center of NW FL. I authorize this center to release medical information needed to determine my benefits or the benefits payable for the related services to the Medicare and Medicaid Services (CMS) agency.

PHYSICIAN SERVICES: I understand that my referring physician will be given the radiologist's report of my scan and can receive a copy of the scan in a CD format if they request one.

PERSONAL VALUABLES: I understand that the PET/CT Imaging Center of NW FL shall not be responsible for the safekeeping of money or valuables, such as jewelry, hearing aids, watches, glasses, dentures, wallets, purses, or clothing. It is my responsibility to keep up with my belongings while in this center.

TELEPHONE, TEXT AND EMAIL CONTACT: I consent to provide my mobile or other telephone number and email address to the PET/CT Imaging Center of NW FL as a means to receive communication including those using automated dialing systems and/or an artificial or prerecorded voice, text messages and electronic mail which may include, but are not limited to, payment-related messages.

AUTHORIZATION FOR MY PET/CT SCAN: I voluntarily consent to have a PET/CT scan performed at the PET/CT Imaging Center of NW FL.

I realize that I have the opportunity to have any questions or concerns about this form fully explained to me. I certify that I have read and understand the contents of this form and that all the information given by me on the Patient Information Sheet is true as of the date of service. The undersigned certifies that he/she has read the foregoing and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

Date: _____

Signature: _____

Printed Name: _____

Relationship to Patient*:* _____