PT Label

AUTHORIZATIONS AND CONSENTS

1. I understand that my treatment at Bluegrass Regional Imaging (BRI), an affiliate of St. Joseph Hospital, is indicated because of my condition. I voluntarily authorize consent to the customary examinations, tests, and procedures performed on patients in my condition to the medical treatment ordered by my physician(s). I understand that Bluegrass Regional Imaging and St. Joseph Hospital are institutes engaged in some practicing and educational functions. As such, attending physicians my be assisted by medical students, interns, residents post graduate fellow, and other non-physical clinical provider student and/or trainees who are independent contractors and not agents or employees of the hospital. I agree to treatment by these persons under the direction of the attending physicians or other appropriate provider.

2. As part of the medical procedures or tests authorized by my doctor or doctors, and if so ordered by him, her or them, I consent to be tested. for human immunodeficiency virus infection (AIDS), hepatitis, or any other blood-borne infections disease, for diagnosis or other purposes directly related to medical treatment. If a health care worker is exposed to my blood aor body fluids, Bluegrass Regional Imaging may at its costs; test my blood for infectious disease. Bluegrass Regional Imaging and/or the hospital shall confidentially maintain to the extent provided by applicable law: a) the fact that a blood test is ordered and, b) the results of such tests.

3. I authorize payment of my insurance benefits to the physician(s) and/or hospital named on my insurance claim form. I further authorize release of information required by any third payor regarding any claim made relating to me. A copy of this form can be used in place of the original. I understand that I am financially responsible for charges not paid by my insurance company within 30 days after billing.

4. I authorize payment of my medical bill from any amount received on by behalf from any person, corporation, or insurance carrier.

5. Applicable to Medicare Patients: I certify that 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 that information to the Social Security Administration, the Medicare Program or their intermediaries or carriers. I request that payment of authorized benefits be made on my behalf.

6. I authorize Bluegrass Regional Imaging and my physician(s) to release any information in their possession to any medical institution or physician responsible for my care subsequent to my treatment at Bluegrass Regional Imaging.

7. I understand that physicians surgeons, radiologist, pathologists, anaesthesiologists, other doctors and physician assistants who may render care or service in my case are not employees or Bluegrass Regional Imaging or St. Joseph Hospital.

8. I acknowledge, authorize, and consent to each of the matters discussed above. I agree to abide by the rules of Bluegrass Regional Imaging, cooperate with physicians and medical personal in my care and treatment, and observe the rights of other patients.

9. I hereby authorize release and retrieval of any medical information necessary to process my insurance claim(s) and interpret my medical images. I also assign all payments from my insurance for services rendered today bo Bluegrass Regional Imaging. I understand and agree to the above conditions and agree that any fees necessary for collection of any outstanding balances are my responsibility. I attest that all information here is accurate and true.

SIGNATURE Witness

x ______________________ ________

patient or person authorized to sign on behalf of patient Date

______________________ ________

personal representative of patient (if unable to sign) Date

____

relationship to patient, if applicable

____

2 witness required if patient unable to sign

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been offered and/or received a copy of Bluegrass Regional Imaging's Notice of Privacy Practices, Dated 04/14/03

SIGNATURE

x ______________________ ________

patient or person authorized to sign on behalf of patient Date

______________________ ________

personal representative of patient (if unable to sign) Date

____

relationship to patient, if applicable

____

Witness

FOR INTERNAL USE ONLY: Patient (or personal representative of the patient) did not sign the ACKNOWLEDGMENT for the following reason (check one)

❑ Patient refused

❑ Patient refused, stating that he/she has already signed ACKNOWLEDGMENT

❑ Patient unable to sign because of medical condition

❑ There was not a personal representaitve of the patient available to sign