Next Generation Imaging

Authorization of Treatment

Name: _____ Date: _____

Social Security # _____ Date of Birth: _____

Physician's Name: _____ Date of Follow-up Appt: _____

Please read and sign the following treatment agreement so that we may proceed with your care and treatment.

MEDICAL TREATMENT PERMIT: I do hereby consent to Next Generation Imaging to perform an MRI, as ordered by a licensed practicing physician.

AUTHORIZATION TO UTILIZE RESULTS AND RELEASE OF INFORMATION: I hereby authorize the use and release of any medical information, including diagnostic imaging studies, necessary to process insurance claims including workmen's compensation or any medical information that is required for any health care related utilization review or quality assurance activities. I also authorize the release of any medical information to my physician, if requested.

ACKNOWLEDGEMENT OF RECIEPT OF PRIVACY NOTICE: I hereby acknowledge that Next Generation Imaging has provided me a copy of their Privacy Notice.

AUTHORIZATION TO CONTACT ME: I authorize Next Generation Imaging to contact me, either by phone or by mail to provide a reminder of appointment, and/or information about any new technology or new services that Next Generation Imaging will be offering. Yes _____ or No _____

ASSIGNMENT OF BENEFITS AND RIGHTS OF RECOVERY: I hereby assign and authorize payment to Next Generation Imaging of all medical benefits, including major medical benefits, to which I am entitled to under any insurance policy or policies, under any self-insurance program, or under any other benefit plan.

I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges incurred by me or anyone on my behalf and I hereby accept such responsibility, including, but not limited to, payment of those fees and charges not directly reimbursed to Next Generation Imaging by any insurance policy, self-insurance program or other benefit plan.

This authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

_____	_____	_____
Print Patient Name	Patient's Signature	Date
_____	_____	_____
Print Witness Name	Witness's Signature	Date