ADVANCED IMAGING
of Redding, Inc.

3T MRI | CT | Ultrasound | X-Ray | *Quality Counts*

PATIENT INFORMATION, ASSIGNMENT AND RELEASE OF INFORMATION, HIPAA NOTICE

TODAY'S DATE: _____
PATIENT NAME: _____
ADDRESS _____
DATE OF BIRTH: ____/____/_____ SOCIAL SECURITY #: _____
GENDER: M ____ F ____ SMOKER?: Yes ___ No ___ For how long? _____
ETHNICITY: African American___ American Indian___ Asian___ Caucasian ___ Hispanic___
Other _____ MEDICATION/FOOD ALLERGY:_____

1. Consent for Diagnostic Procedures

I do hereby voluntarily consent to such diagnostic procedures as deemed necessary by my ordering physician. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of such diagnostic procedures.

2. Consent for Release of Information

I authorize any and all medical facilities to release information relating to my diagnostic procedures to Advanced Imaging of Redding, Inc. I authorize Advanced Imaging of Redding, Inc. and my ordering physician to release any information concerning and related to my diagnostic procedures at Advanced Imaging of Redding, Inc. including the reproduction of any and all medical or billing records to the Social Security Administration, Medicare, Medicaid (for their various intermediaries) when requested for payment, utilization review or for coverage determination purposes. **A COPY OF MY RESULTS SHOULD ALSO GO TO:**

CC: NAME_____FAX:_____
CC: NAME_____FAX:_____
CC: NAME_____FAX:_____
CC: NAME_____FAX:_____

3. Assignment of Benefits and Rights

I hereby authorize payment to be made to Advanced Imaging of Redding, Inc. and fully understand that I am the financially responsible party in the event that my insurance denies these services or states that these services are "not medically necessary. I assign all benefits and rights under any and all insurance contracts, self-insurer programs, or from any third party payer. This assignment shall include the authority and right to institute legal action to recover all amounts due as a result of said services rendered including any and all statutory penalties that may also be claimed and collected. A photocopy of this authorization and assignment shall serve as an original. The undersigned unconditionally guarantees payment of all costs associated with the diagnostic study performed and assumes financial responsibility to Advanced Imaging of Redding, Inc for any balance not covered by this agreement.

4. HIPAA Privacy Notice

We are required by law to maintain a HIPAA Privacy Notice and make it available to patients upon request. I acknowledge that I am aware of this Notice and I understand a copy of such Notice is available to me if requested. I prefer to be reached at the following phone number: _____

I authorize Dr. Hecht and his staff to discuss my protected health information with the following persons:

Name _____ Phone #_____ Relationship _____
Name _____ Phone # _____ Relationship _____

_____ _____
SIGNATURE OF PATIENT/GUARDIAN DATE