Delaney
Radiologists

DELANEY RADIOLOGISTS GROUP
CONDITIONS OF EXAMINATION

CONSENT FOR EXAMINATION:

The undersigned presents for diagnostic examination by Delaney Radiologists and hereby consents to medical services including such diagnostic, ultrasound, MRI, CT, radiology and/or intravenous procedures, as may be deemed necessary by my referring physician and the radiologist. The undersigned is aware that the practice of medicine and radiology is not an exact science and acknowledges that no guarantee has been made or implied to the patient as to the results of this examination.

REQUEST FOR PAYMENT, ASSIGNMENT OF BENEFITS FOR MEDICARE/MEDICAID PATIENTS:

The undersigned requests payment of authorized Medicare/Medicaid benefits for any services furnished to the patient by Delaney Radiologists and hereby assigns such benefits directly to Delaney Radiologists. The undersigned authorizes Delaney Radiologists to submit a claim for such services to Medicare and certifies that the information they have provided is correct.

ASSIGNMENT OF BENEFITS FOR ALL OTHER INSURANCE CARRIERS:

The undersigned hereby assigns and authorizes Delaney Radiologists to submit a claim to their insurance carrier or their agents for all covered services rendered by their physicians and direct the insurance carrier or their agents to pay them.

FINANCIAL AGREEMENT:

The undersigned understands and agrees that the patient and guarantor are financially responsible to Delaney Radiologists for charges of medically necessary services or services requested by or on behalf of the patient if such services are not covered by the patient's hospitalization plan, insurance, or Medicare/Medicaid.

I certify that I have read this form and reasonably understand its contents and that the information provided by me is true and correct.

Signature of Patient	Print Patient's Name	Date

IF PATIENT IS UNDER 18 YEARS OF AGE, PARENT OR GUARDIAN MUST SIGN BELOW:

Signature of Parent or Guardian	Print Name of Parent or Guardian	Date

CONSENT TO OBTAIN MEDICAL RECORDS:

I give consent for Delaney Radiologists to obtain, as deemed necessary, from any physician, hospital or other medical provider, any study and/or information regarding my medical history, symptoms, treatment, examination results, or diagnosis relating to the exam performed on the indicated date of service

Signature of Patient or Guardian	Print Patient's Name	Today's Date

CONSENT TO RELEASE MEDICAL RECORDS:

List anyone (relatives/friends only) to whom you will allow access to/release of your medical records - applies to today's exam(s) only:

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

This authorization is good for 180 days and applies only to exams performed on TODAY'S date of service. I may revoke this authorization at any time by notifying Delaney Radiologists in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.

Signature of Patient or Guardian	Today's Date