

**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 Northwest Florida 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 also authorize the *PET/CT* Imaging Center of Northwest Florida to release my medical records to the individuals listed below. I may request the complete privacy practices statement of the *PET/CT* Imaging Center of Northwest Florida 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 Northwest Florida.

***FINANCIAL AGREEMENT:*** For and in consideration of services rendered, the undersigned agrees to pay the *PET/CT* Imaging Center of Northwest Florida 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, the undersigned agrees to pay all collection and legal expenses incurred by the center including reasonable attorney's fees.

***STATEMENT TO PERMIT PAYMENT OF MEDICAREIMEDIGAP BENEFITS TO PROVIDER:*** I request
payment of authorized Medicare/Medigap benefits be made on my behalf to the *PET/CT* Imaging Center of Northwest Florida. 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) and my Medigap insurance company.

***PHYSICIAN SERVICES:*** I understand that my referring physician will be given the radiologist report concerning this scan and will have the opportunity to have a copy of the actual scan in a CD format if they request one.

***PERSONAL VALUABLES:*** I understand that the *PET/CT* Imaging Center of Northwest Florida 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.  **\_\_\_\_\_\_\_\_\_\_** ***(initial)***

***AUTHORIZATION FOR MY PET/CT SCAN:*** I voluntarily consent to having a *PET/CT* scan performed at the
*PET/CT* Imaging Center of Northwest Florida. I realized 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 form 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 Narne: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**My medical records can be fully disclosed and/or released to the below listed individuals:**

 Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_