Up Right MRI
OF COLORADO

AUTHORIZATION FOR TREATMENT
RELEASE OF INFORMATION
ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES

CONSENT FOR MEDICAL SERVICES: Consent is given to Upright MRI of Colorado, its contractors, and its employees to provide medical services and administer physician orders. Certain procedures require separate consent. The undersigned also authorizes observers to be present during my MRI for purposes of their medical training and education.

PERSONAL VALUABLES: Upright MRI is not responsible for personal property. I will be instructed to remove all personal items/ devices prior to my MRI and a locked dressing room will be provided to place all personal items in during my MRI.

ASSIGNMENT OF BENEFITS: I authorize payment of benefits, including insurance benefits, otherwise payable with respect to the patient, to Upright MRI of Colorado. I also agree to assist in the processing of claims for benefits.

MEDICARE AUTHORIZATION: I certify the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize Upright MRI of Colorado to release any information requested by the Social Security Administration and Healthcare Financing Administration or its intermediaries to process this or any related Medicare claim. I request the payment of authorized benefits be made on my behalf to Upright MRI of Colorado.

FINANCIAL RESPONSIBILITIES: I agree to pay all medical charges to the extent not expressly prohibited by applicable law. It is understood that if any injury or medical condition is determined not to be work or auto related, the undersigned is responsible for payment in full. I understand and agree to the following policies regarding financial and insurance responsibilities: I understand it is my responsibility as the patient to verify the network participation, benefit coverage, and authorization status of services provided to me at Upright MRI of Colorado. Upright MRI of Colorado will assist me as much as possible in understanding whether my insurance will cover services provided to me, but given the uncertainty that pervades insurance decisions, Upright MRI of Colorado cannot be responsible for any information that turns out to be incorrect. **Payment is due in full at the time of service unless financial arrangements have been agreed upon prior to my services.** Past due accounts will be transferred to a collection agency if accounts are not paid for in full within 120 days from the date of my first statement. I am responsible for charges incurred for all treatment rendered. This responsibility includes co-payments, deductible amounts, non-covered and excluded items not paid for by my insurance carrier or other party responsible for coverage of my medical expenses. I also agree that I am responsible for any payments for services my insurance carrier determines, either now or later, to be unreasonable or not medically necessary.

CONSENT FOR RELEASE OF MEDICAL RECORDS/CONFIDENTIAL INFORMATION: I hereby authorize Upright MRI of Colorado to release any medial information requested by a physician, other health care provider, insurance company, attorney, employer, or any other entity which may be concerned with my medical records and/or payment of charges incurred at Upright MRI of Colorado.

CONSENT FOR EMAIL AND TEXT MESSAGES: I hereby authorize Upright MRI of Colorado to contact me via email and/or text messaging for appointment reminders, billing communication and requested results. I understand that emails and text messages are generated using a secure system. However, they are transmitted over a public network to a personal phone/email and as such may not be secure.

HIPAA - NOTICE OF PRIVACY PRACTICES: I acknowledge that I have reviewed the posted Upright MRI of Colorado Notice of Privacy Practices which contains a complete description of the uses and disclosures of my health information and will be provided with a copy upon request.

X_____ /_____

Signature of patient or authorized representative Date

_____ Relationship to patient