Upright MRI of Colorado
6726 S. Revere Pkwy #100
Centennial, CO 80112

AUTHORIZATION FOR TREATMENT
RELEASE OF INFORMATION

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 a separate Consent. The undersigned authorizes observers to be present during the procedure (Scan) for purposes of their medical training and education.

PERSONAL VALUABLES: Upright™ MRI of Colorado is not responsible for personal property.

ASSIGNMENT OF BENEFITS: The undersigned authorizes payment of benefits, including insurance benefits, otherwise payable with respect to the patient, to Upright™ MRI of Colorado. The undersigned agrees 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 any holder of medical or other information about me to release the Social Security Administration and Healthcare Financing Administration or its intermediaries or carriers of any information needed for this or a related Medicare claim. I request the payment of authorized benefits be made on my behalf to Upright™ MRI of Colorado.

FINANCIAL RESPONSIBILITY: The undersigned agrees to pay all medical charges to the extent not expressly prohibited by applicable law (i.e. Workers' Compensation/Medicaid). It is understood that if any injury or medical condition is determined not to be work-related, the undersigned is responsible for payment in full. I understand and agree to the following policies regarding financial and insurance responsibilities: Payment is due at the time of service (cash, check, VISA and MasterCard). 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 at a later date, to be unreasonable or not medically necessary. I understand that Upright MRI of Colorado will assist me as much as possible in understanding whether my insurance will cover any particular expenses, but given the uncertainty that pervades insurance decisions, cannot be responsible for any information that turns out to be incorrect.

CONSENT FOR RELEASE OF MEDICAL RECORDS/CONFIDENTIAL INFORMATION: I hereby authorize the above-named agency to release any medical information requested by attorney, physicians, insurance companies, employers, health care providers or any other entity which may be concerned with my medical records and/or payment of charges incurred at Upright™ MRI of Colorado.

This will authorize: **Upright™ MRI of Colorado**

Facility/Individual Releasing Information
Mailing Address

To release the following information to: ______________________________

____

Patient (or Authorized Representative/Relationship to Patient)

____

Date

To the receiving party of this information – this information has been disclosed to you for the sole purpose stated in this consent. Any other use of this information without the expressed written consent of the patient is prohibited. These records may be protected by Federal Regulation (42 CFR part 2).