Summit Diagnostic Imaging Center

Payment Authorization

I request that payment by my insurance carrier, worker's compensation carrier, and/or Medicare be made on my behalf to Summit Diagnostic Imaging Center for any services provided to me. I authorize the release of any medical information to my insurance company and/or Health Care Financing Administration and its agents necessary to determine these benefits. I agree to pay any balance of expenses not covered by my insurance plan and/or Medicare. If no insurance will be filed, I agree to pay for services rendered.

I hereby authorize Summit Diagnostic Imaging Center to request copies of my medical or pathology reports and/or films as needed for review by the radiologist interpreting my imaging procedures.

Signed: _____ Date: _____

Patient Name (Print): _____

DOB: _____ Date of service for records being requested: _____

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ALL MEDICARE BENEFICIARIES WITH MEDIGAP INSURANCE AND/OR SECONDARY INSURANCE TO MEDICARE

I request that payment of authorized Medigap benefits and/or secondary insurance that follow Medicare be made on my behalf to Summit Diagnostic Imaging Center for any services provided to me.

Signed: _____ Date: _____

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AUTHORIZATION OF RELEASE OF MEDICAL INFORMATION

I hereby authorize Summit Diagnostic Imaging Center to release information and/or copies of records pertaining to my medical history, medical care, billing and/or filing of insurance to the following individuals:

1. _____ (relationship) _____
2. _____ (relationship) _____

Patient Signature: _____ Date: _____

(This authorization will expire 12 months from the date signed)