



Howard Open MRI Center
 6100 Day Long Lane, #107
 Clarksville, MD 21029
 PH: 410.531.1900 FX: 410.531.0484
Comfort and Peace of Mind.

Patient Authorizations and Acknowledgements

Patient:		Date of Birth:	
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My signature and date below authorizes and acknowledges:

- Authorizes Howard Open MRI Center to direct bill Medicare, Medicaid, Medicare Supplemental or any other insurance on my behalf.
- Authorizes the release of my medical information to my physician and to Medicare, Medicaid, Medicare Supplemental or other insurance and their agents and assigns.
- Authorizes and gives my permission to Howard Open MRI Center to obtain pertinent records from a hospital, medical facility or care provider who has been involved in my healthcare. Howard Open MRI Center may request medical records, for example prior imaging reports (CT, MRI, US, X-ray) or surgical/ pathology reports, which pertain to the reasons I am seeking care on this visit. This information will not be distributed beyond Howard Open MRI Center, and will be kept confidential.
- Authorizes Howard Open MRI Center to obtain medical or other information necessary in order to process my claim(s) including determining eligibility and seeking reimbursement.
- Acknowledges that I am financially responsible for any service not covered by my insurance as well as any co-payments, co-insurance and deductibles. I understand that if my account becomes delinquent, a rate of 1.5% will be applied monthly to the delinquent balance until the debt is paid in full.
- Acknowledges that should collection proceedings or other legal action become necessary, I understand that Howard Open MRI Center has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect my unpaid account. Further, I understand that in addition to my account balance, I am responsible for all attorney's fees, court costs, collection agency costs, and other assessments incurred to collect my unpaid account balance.
- Acknowledges that I have access to a copy of Howard Open MRI Center's *Notice of Privacy Practices* which is available in the reception area of the facility.
- **FOR MINORS ONLY: For Parents/Guardians of Minors:** I, _____, the parent/legal guardian of _____ hereby give my consent for this test.

Patient Signature: _____ **Date:** _____