Advanced Medical Imaging
Phone:(785)856-0224 Fax:(785)330-5652

Patient Name **Patient date of birth**

Receipt of HIPAA Privacy Policy Notice

I hereby acknowledge that I received the Notice of Privacy Practices from ADVANCED MEDICAL IMAGING, which sets forth the ways in which my personal health information may be used or disclosed by ADVANCED MEDICAL IMAGING and outlines my rights with respect to such information.

Financial Agreement

***Payment is required at the time of service.** Payment may be made by cash, check, or major credit card. Any deductible, co-insurance, or co-payment is payable at time of service.

*Advanced Medical Imaging reserves the right to transfer unpaid balances to outside entities for collections, such as banks or other financial institutions.

* I hereby authorize the office of Advanced Medical Imaging to release any medical information required during the course of examination/ treatment and permit payment directly to them any benefits due for their services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes, but not limited to, co-insurance, co-payment, deductible, and non-covered services.

*I acknowledge the amount collected and quoted to me are an estimate based on my current insurance benefits, and the insurance information we have on file. I understand that my balance left after payment by my insurance company is my obligation.

*If you have chosen not to use your health insurance, you are accepting our cash pay pricing and agree that you will not submit this to your health insurance to be applied toward your deductible or out of pocket maximums.

I have read and understand all the of the above and have given truthful information to the best of my knowledge.

Patient/Patient representative signature **Relationship** **Date**