MRI of America, LLC ("MRI")

Assignment of Insurance Benefits, Release of Protected Health Information, Consent for Treatment, Guaranty, and Statement of Service

I hereby assign and authorize payment made directly to MRI of all of my covered health insurance benefits, including Medicare, Medicaid, Medigap, HSA, commercial, all third party payors, or private managed care plans and insurance, whether payable directly to me by any or all third party payors. I understand my health insurance plans or third party payors may not cover part or all of the medical services rendered. I fully understand I am financially responsible for and agree to pay all charges not paid by my health insurance plans or payors, including deductibles and co-insurance regardless of reason given for non-payment. I agree to immediately forward all payments, explanations of benefits, and correspondence sent directly to me from any and all third party payors related to the care rendered by MRI and agree that failure to do so will make me responsible for the entire billed charged. My assignment of benefits covers MRI physicians and surgical centers for all services now rendered and to be rendered in the future until this assignment is revoked. This assignment of benefits supersedes any previous assignments or agreements I made with my insurance company, including Blue Cross Blue Shield and their related companies or any other third party payor(s) to pay me directly. A copy of this form shall be considered as valid as the original.

I have disclosed the names of all my health insurance plans and third party payors, including secondary plans, and I represent such health care coverage is in full force and effect at this time. I also aggress to promptly notify MRI of any changes in my health insurance plan and/or coverage as well as any changes in my address and phone number. I understand that my failure to do so may make me fully responsible for the entire bill. In consideration of the services furnished to me, I hereby agree to pay any balance due within thirty (30) days from presentation of my bill. If my account should become delinquent, and collection efforts become necessary, I agree to pay one-percent (1%) per month delinquency charges and any reasonable collection and/or attorney fees incurred. I further agree that Arapahoe County, Colorado, will be the venue for any collection efforts including small claims court and for any and all other litigation required to collect amount due.

I understand it is ultimately my responsibility to obtain all required authorizations and/or pre-certifications for medical services that are required by my health insurance plans and/or third party payors. I acknowledge that this is not the responsibility of MRI. I also acknowledge no guarantees have been made by any employee of MRI or any other party about: (1) my treatment; (2) whether it will be paid for by any third party payor(s) or health insurance plans; or (3) whether any care rendered by MRI including but not limited to physician services, radiology services, and surgical center fees are in or out of network with my insurance plans. I agree to fully cooperate with MRI to assist in their efforts to get claims paid on my behalf but understand that ultimately I am financially responsible for, and agree to pay, and unconditionally guaranty payment, of all charges not paid by my health insurance plan or third party payors. I also authorize the release of protected health information as may be required for: (1) my treatment; (2) to process insurance claims; (3) to answer any inquiries from third parties that result from actions initiated by the patient; and (4) to support the operation of the medical practice. It is expressly understood this information will be used only for these purposes. I acknowledge that I have had an opportunity to review and ask questions regarding HIPAA privacy notice. I understand that I have the right to refuse treatment, to refuse to allow the participation of students in my care, or to refuse to participate in experimental research.

I have read the above and consent to the term and conditions stated.

_____ _____

Signature(s) of patient and/or insured Date

_____ _____

Patient's social security number Patient'