Johns Creek Diagnostic Center
Assignment of Benefits/Authorization for Treatment

CONSENT FOR MEDICAL TREATMENT: I hereby authorize Johns Creek Diagnostic Center to furnish the necessary medical or surgical treatment or procedures, including diagnostic, x-ray, drugs and supplies as may be ordered by the attending physician(s) or designee. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as the result of my treatment. I recognize that the physician practicing at Johns Creek Diagnostic Center is not employed as such, but is an independent radiologist. Johns Creek Diagnostic Center may delegate to this physician those services normally provided, and any questions relating to the care given by the physicians should be directed to him/her.

_X_ **ASSIGNMENT OF BENEFITS:** I hereby authorize payment directly to Johns Creek Diagnostic Center of any and all medical benefits applicable and otherwise payable to me. I understand that I am financially responsible to Johns Creek Diagnostic Center for charges not covered by this assignment.

_X_ **AUTHORIZATION FOR RELEASE OF INFORMATION:** I hereby authorize Johns Creek Diagnostic Center to release any information regarding diagnosis and treatment requested by the insurance company necessary to collect benefits under the policies stated at the time of treatment, or any policies which I subsequently make claim against for hospital services, including related physicians' services on this or related dates of services. Unless noted below, this authorization includes, but is not limited to, the release of information to drug, alcohol, HIV antibody and/or psychiatric treatment and/or testing. *Withhold from release*: _____. I further authorize any physician or institution that attended me previously to furnish medical records or information which may be requested by Johns Creek Diagnostic Center or the attending physicians.

___ **LIFETIME MEDICARE B SIGNATURE AUTHORIZATION:** I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or the billing agent of Johns Creek Diagnostic Center, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical benefits be made to the holder of this assignment on my behalf. I understand that I am responsible for any health deductibles and coinsurance.

___ **MEDIGAP:** I request that payment of authorized Medigap benefits be made on my behalf to Johns Creek Diagnostic Center for any services furnished to me by them. I authorize any holder of medical information to release to _____ any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical benefits be made to the holder of this assignment on my behalf. I understand that I do not need to provide my supplemental insurer with information concerning this Medicare claim, because my signing this authorization will cause Medicare payment to cross over automatically.

Name of insured: _____

Company Name: _____ Policy#: _____

___ **LIABILITY INSURANCE WAIVER:** I hereby state that I wish Johns Creek Diagnostic Center to submit my claim for medical services to: _____ for services rendered concerning the accident date of ___/___/___. I am not filing this claim with any other liability insurance and will not be making any claim to any other general liability insurance or company. I understand that if I do submit this to any other general liability insurance company that _____will have to be refunded immediately and the total amount originally charged for the services rendered will become due and payable by me. (Filing your liability insurance does not constitute an assignment. If this is a legal case, we do not accept assignment pending the outcome of your case. You are responsible for your bill in its entirety.)

___ **WORKERS COMPENSATION:** This authorizes my physician to furnish written reports and communicate orally with any representative, attorney for, or investigator from my Workers' Compensation Carrier, _____ regarding my examination, diagnosis, treatment and prognosis concerning injuries sustained as result of an accident occurring on the following date ___/___/___.

___ **PATIENT UNDER 18:** I hereby give my permission for _____to be treated by Johns Creek Diagnostic Center.

_____	_____	_____
Signature	Witness	Date

_____	_____	_____
Patient/Guardian Signature	**Witness**	**Date**