Diagnostic Imaging Center of Terrebonne
a TGMC affiliate

A. Consent for Examination and Treatment: I hereby authorize the providers and employees of Diagnostic Imaging Center of Terrebonne ("DICT") to provide medical treatment/services which includes, but is not limited to, performing and administering tests and diagnostic procedures that are deemed necessary, including, but not limited to imaging examinations as may be required by the center, or may be ordered by my physician(s) or persons working under the general and/or special instructions of my physician(s).
   1. I understand and agree that this consent covers all authorized persons, including but not limited to physicians, residents, nurse practitioners, physicians' assistants, specialists, consultants, radiology technicians and independently contracted physicians, who are called upon by the physician in charge, to carry out the diagnostic procedures.
   2. I hereby authorize and give DICT providers and employees to take photographs, images or videotapes of such diagnostic procedures of Patient as may be required by DICT or as may be ordered by a physician. With the exception of radiologic images, DICT is not obligated and does not retain videotapes or photographs for any period of time, if the medical record contains a record of the diagnostic procedure. I further acknowledge and agree that DICT may use cameras or other devices for patient monitoring.
   3. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the outcome of any tests.

B. Authorize for Release of Information: I understand that my insurance company and/or their agents may need information necessary to make determinations about payments/reimbursement. I hereby provide authorization to release to all insurance companies, their successors, assignees, and other parties with whom they have contracted, or others acting on their behalf, that are involved with payment for any diagnostic charges incurred by the patient, any information that they request and deem necessary for payment/reimbursement, and or quality review. I further authorize the release of my health information to physicians and other health care practitioners on staff who are involved in my health care now and in the future, and to other health care providers, entities, or institutions for the purpose of my continued care and treatment, including referrals.

C. Medicare Patient's Certification and Authorization to Release Information and Payment Request: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration, or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

D. Assignment of Insurance Benefits: I hereby authorize any and all insurance companies, health plans, defined benefit plans, health insurers, or any entity that is or may be responsible for payment of my medical expenses to pay all diagnostic center medical benefits now due, and to become due and payable to me under any diagnostic center benefits, sick benefits, injury benefits and any other benefit for services rendered to me, including Major Medical Benefits, direct to DICT and all independently contracted physicians. I assign any and all rights that I may have against any and all insurance companies, health plans, defined benefit plans, health insurers or any entity that is or may be responsible for payment of my medical expenses, including, but not limited to any right to appeal a denial of a claim, any right to bring any action, lawsuit, administrative proceeding, or other cause of action on my behalf. I specifically assign my right to pursue litigation against any and all insurance companies, health plans, defined benefit plans, health insurers or any entity that is or may be responsible for payment of my medical expenses based upon a refusal to pay charges.

REGISTRATION AUTHORIZATION	MRN: DOB: Age: Sex:

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E. Valuables: It is understood and agreed that DICT is not liable for the damage to or loss of any money, jewelry, documents, dentures, eye glasses, hearing aids, prosthetics, or any other property of value.

F. Acceptance of Financial Responsibility: I agree that in considerations of the service and supplies that have been or will be furnished to the patient, I am hereby obligated to pay all charges made for the account of the patient according to the standard rates (in effect at the time the services and supplies are delivered) established by DICT. I understand that I am responsible for all charges, or portions thereof, not covered by insurance or other sources. Patient refunds will be distributed only after balances at DICT are paid.

G. Communication Authorization: I hereby authorize DICT and its representatives, along with any billing service or collection agent who may work on their behalf, to contact me on my cell phone and/or home phone using pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging, or by any other form of electronic communication. This includes, but is not limited to, appointment reminders, yearly physical exam reminders, preventative care reminders, patient campaigns, welcome calls and calls about account balances on my account or any account on which I am listed as a guarantor. I understand I have the right to opt out of these communications at any time.

H. Relationship Between Facility and Physician: I understand that some, but not all, providers furnishing services to the patient are not employees or agents of DICT. The patient is under the care and supervisions of his/her referring physician, and it is the responsibility of the facility to carry out the instructions of such physicians. It is the responsibility of the patient's physician/designee to obtain the patient's informed consent, when required for special diagnostic procedures rendered for the patient under the special instructions of the physician/designee.

I. Notice of Privacy Practices: I acknowledge I have received a copy of DICT's Notice of Privacy Practices.

J. Term: This authorization is valid for this and subsequent care/treatment I receive at DICT and will remain valid unless/until revoked in writing by me.

Patient/Legal Guardian Signature	Witness Signature
Printed Name Relationship to Patient	Printed Name
REGISTRATION AUTHORIZATION	MRN: DOB: Age: Sex: