



Patient Name: _____

Consent for Admission and Treatment

I request admission to SNI Imaging and authorize SNI Imaging, staff, and physicians, to provide routine care, and perform the following procedure(s):

_____ or diagnostic procedures, x-ray treatments as may be necessary in the course of treatment of the above named person. I have not been given a guarantee as to the results of the examination.

Is patient currently living in a skilled nursing facility? Yes No

I (we) authorize SNI Imaging to release information acquired in the course of the examination and treatment of the above named, to physicians and to physician's billing services, insurance companies (or their agents) for reimbursement purposes, and/or other institutions or organizations performing special tests or providing special equipment or transportation, and/or to local state or federal agencies in accordance with applicable laws.

I (we) **DO** _____ **DO NOT** _____ consent to the presence of students, residents/fellows and or vendors in the exam room to observe/assist the procedure. I am aware that only the Radiologist may grant this permission on my consent.

SNI Imaging does not honor any predetermined Advanced Directives. If you have any questions please talk to your physician.

Your physician may be a partner in ownership of this Facility, if you would like to see a list of our owners please ask the Receptionist.

The physicians and other pertinent independent licensed practitioners and/or independent contracted services practicing at SNI Imaging are licensed and qualified to practice in the state of Missouri. These practitioners provide medical care at this facility, but they are not agents or employees of SNI Imaging.

Financial Agreements: For services hereto performed or to be performed for the Patient by this Facility below signed whether as patient, agent or guarantor, agrees and promises to pay the charges for the care so provided to the Patient by Facility in accordance with SNI Imaging's then current standard rates and all costs incurred in collecting same, together with attorney's fees, which SNI Imaging deems necessary and reasonably required to enforce the rights of SNI Imaging.

Assignment of Insurance Benefits to SNI Imaging: As or on behalf of the insured under the insurance specified on the registration documents of the Patient, and otherwise payable thereto (the present and future rights thereto and monies due or to become due there from termed "Contract Rights", the below signed irrevocably assigns and transfers to SNI Imaging the Contract Rights, and orders and directs such insurer(s) to pay all monies due or to become due there under directly to SNI Imaging or its assignee. To effect such payment SNI Imaging is irrevocably constituted and appointed in fact with substitution power, to sue or otherwise collect and settle any claim under the Contract Rights as insured without further notice or approval of insured and to endorse in the name of the insured any check or other instrument for the payment of monies there under.

If insured receives monies directly for the insurer(s), same shall be held in trust and immediately transferred to SNI Imaging for amounts due. This assignment is irrevocable with interest until full and complete payment of all monies due SNI Imaging and its affiliates from this event of admission or otherwise. Money received by SNI Imaging from insurer(s) or other third party sources, less the expense in procuring same, shall be deducted from the principal amount due for services rendered to the Patient. If charges not covered by insurance can not be paid in full when due, below signed agrees upon request to sign a promissory note bearing interest at the maximum legal rate to pay all debt not paid, if credit is approved.

Medicare Assignment: Patient's Certification, 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 be released to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claims. I request that payment of authorized benefits be made on my behalf.

I (We) the undersigned certify that I (We) have read and fully understand this "Conditions of Treatment" Form.

Patient Signature

Date

Patient is a minor _____ years of age AND/OR is unable to consent because: _____

Relative/Authorized Agent

Relationship to Patient Date

Witness

Date