ABERCROMBIE RADIOLOGICAL CONSULTANTS, INC.

PAYMENT AUTHORIZATION

I request that payment by my insurance carrier and/or Medicare be made on my behalf to Abercrombie Radiological Consultants, Inc. for any services furnished to me. I authorize the release of any medical information, to my insurance company and/or Health Care Financing Administration and its agents, necessary to determine these benefits. I agree to pay any balance of expenses not covered by my insurance plan or Medicare.

I hereby authorize Abercrombie Radiology to request copies of my medical or pathology reports and/or film as needed for review by the radiologist interpreting my imaging procedures.

Signed: ____ Date:_________________

Patient Name (Print): ____

DOB: __________________________ Date of service of records being requested: _____________________

ALL MEDICARE BENEFICIARIES WITH MEDIGAP INSURANCE AND/OR SECONDARY INSURANCE TO MEDICARE

I request that payment of authorized Medigap benefits and/or any secondary insurance that follow Medicare be made on my behalf to Abercrombie Radiological Consultants, Inc. for any services furnished to me.

Signed: ____ Date: _________________

A representative of Abercrombie Radiology may contact me by:

_______ Home Phone ________________________________
(Number)

_______Cell Phone (includes text messaging) ____________________________________
(Number)

_______ Work Phone ____
(Number)

AUTHORIZATION OF RELEASE OF MEDICAL INFORMATION

I hereby authorize Abercrombie Radiological Consultants to release information and/or copies of records pertaining to my medical history, medical care, billing and/or filing of insurance to the following individuals:

1.____ (relationship) _______________________

2.____ (relationship) ________________________

Patient Signature ____ Date: ______________________
(This authorization will expire 12 months from the date signed)