

CHRISTIANA CARE IMAGING SERVICES

INSURANCE AUTHORIZATION

PLEASE READ: All charges are due at the time of service. All professional services rendered are charged to the patient, necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our office.

MAMMOGRAPHY SERVICES CONSENT

I consent to a mammogram (breast x-ray). I am not pregnant, nor am I nursing a baby. I understand the procedure, purpose and possible risks of the mammogram. I understand that a mammogram is only one part of a complete breast examination, and it does not detect all breast cancer. Physical examination, other tests, and interpretation of all results will complete the breast evaluation.

I understand information regarding my mammogram will be sent to the physician whose name and address I have provided. I authorize those individuals with a need to know to be able to retrieve my records, whether they are maintained on paper or electronically. I understand that if my mammogram is suspicious for malignancy, or if an abnormality is found, I will need to be further evaluated by a physician.

Signature: _____ Date: _____

IMAGING SERVICES MEDICAL RECORDS RELEASE

If I have previous films, I authorize that imaging center(s) to release my films to the Christiana Care Imaging Services for the purpose of a comparative study. (Authorization expires 120 days from date of signature). If further diagnostic studies are necessary, I consent to the release of the test results to the Christiana Care Imaging Services.

The information contained above is correct to the best of my knowledge,

Signature: _____ Date: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Christiana Care Health Initiatives to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. I authorize Christiana Care Health Initiatives to release any medical information concerning my care to my insurance company for the purpose of obtaining benefits to process claims.

Signature: _____ Date: _____

MEDICARE ASSIGNMENT OF BENEFITS

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Christiana Care Health Initiatives for any services furnished me by physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services.

Signature: _____ Date: _____

Patient or Authorized Representative

THANK YOU FOR CHOOSING CHRISTIANA CARE FOR YOUR HEALTH CARE NEEDS.