VALLEY IMAGING CENTER
22281 US HWY 72 EAST, SUITES B & C, ATHENS, AL 35613
TEL: 256-233-2158 -- FAX: 256-230-6825

Patient Name: _____ Date of Birth: _____ Acct # (staff use): _____

I, the patient named above, do hereby authorize Valley Imaging to perform a X-ray, CT, MRI, Ultrasound, Mammogram, Nuclear Medicine, Fluoroscopy, or/an Bone Density study/studies including any examination deemed necessary to complete the study/studies that are considered diagnostically necessary. I consent to any emergency treatment necessary during the procedure. I further consent to the administration of such **oral or IV contrast media, sedatives, anesthesia, or other preparation** necessary for completion of the study with the exception(s) of:

_____.

(write **NONE** if no exceptions)

If female, I certify to the best of my knowledge, I am not pregnant at this time, or if I am knowingly pregnant, I have informed Valley Imaging and freely decide to submit myself to the X-ray, CT, MRI, Ultrasound, Fluoroscopy, Nuclear Medicine and/or Bone Density procedure, examination, contrast media, preparation, etc., as indicated above.

I hereby certify that I have read the notice of privacy practices of Limestone Radiology Associates, P. C., dba: Valley Imaging Center and my patients rights as listed on that notice. I understand and hereby agree to its terms. I understand my medical information may be electronically transferred to my physician, specialist, hospital, insurance company, collection agency or lawyer(s) that may require such information as needed to provide adequate treatment pertaining to this episode of care. Valley Imaging Center **will not** sell medical information for marketing purposes or medical research.

Insurance will be filed as a convenience to you. I authorize the release of any medical information needed to process an insurance claim. I authorize payment of medical benefits to Valley Imaging Center for any study I have completed. If you do not have insurance, payment arrangements must be made **prior** to your exam. If your insurance does not respond within forty-five (45) days of our filing, we will notify you. **Any remaining balance after insurance pays becomes your responsibility and is due upon receipt of your bill.** Arrangements may be made in cases of financial hardship. If patient account becomes delinquent, it will be transferred to a collection agency representing this Practice. The patient will be solely responsible for all expenses pertaining to the collection process, collection fees, legal fees, and court costs.

Your **X-ray, CT, MRI, Ultrasound, Nuclear Medicine, Mammogram, Bone Density** films and reports will be made available directly to your referring physician within two (2) working days of your exam. You may come to Valley Imaging Center and sign a release to pick up your films. **Mammograms films are originals and will need to be returned** to our office. When you and your physician have completed your treatment, these may be needed by us for comparison with a future study you may have.

AUTHORIZATION FOR OTHERS TO PICK UP YOUR FILMS, ETC.:
If you cannot pick up your films, reports, or medical information from us, only the following person(s) may do so for you:

_____

Printed Name Relationship Cell or Home Telephone #

_____

AUTHORIZATION TO RELEASE PATIENT FILMS AND REPORTS TO OTHER PROVIDERS:
I, the patient named above, do hereby authorize the release of all relevant X-ray, CT, MRI, Bone Density, Mammography, Nuclear Medicine, Fluoroscopy and Ultrasound films and reports to the custody of: Valley Imaging Center, Athens, Alabama 35613. I do certify I have read or have had read to me, the above statements and fully understand the procedure and/or treatment to be performed. I understand there are no guarantees or assurances of the results of the procedure(s) to be performed.

_____ _____

Patient Signature Date

Note: Authorization must be signed by patient, legally-appointed guardian (if patient is a minor or physically/mentally impaired), or legally authorized representative.

_____

Witness

DC