ZILKHA RADIOLOGY

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1161 Montauk Highway; West Islip, NY 11795-4930 Tele (631) 669-1717 Fax (631) 669-2227

ASSIGNMENT OF BENEFITS

I/We hereby assign to Zilkha Radiology, (Long Island MRI, PC/ Long Island Medical Imaging, PC/Long Island Medical Diagnostic Imaging, PC) all monies and /or benefits to which I/We may be entitled from government agencies, insurance carriers, or those who are financially liable for my medical care to cover the costs of the care and treatment rendered to myself or my dependents.

I/We hereby authorize and direct Zilkha Radiology, (Long Island MRI, PC/ Long Island Medical Imaging, PC/ Long Island Medical Diagnostic Imaging, PC) to release to governmental agencies, insurance carriers, or to whoever is financially liable for my medical care, all information needed to substantiate payment for such medical care.

I fully understand that I am financially responsible for my deductible, co-payment, co-insurance, and charges not covered by my health insurance plan or as discussed above. I understand that the information listed above will stay in effect as long as I am a patient with Zilkha Radiology.

******IF WE REFER YOUR ACCOUNT TO A COLLECTION AGENCY YOUR ACCOUNT WILL BE INCREASED BY 25%. IF WE REFER YOUR ACCOUNT TO AN ATTORNEY YOUR ACCOUNT WILL BE INCREASED BY 25% PLUS COURT COSTS.**

HIPAA ACKNOWLEDGEMENT

The HIPAA policy provides national standards to protect the privacy of your personal health information. There are copies posted throughout our waiting rooms. By signing below you are confirming that you understand these policies and are in agreement with them. Copies are available upon request at any time.

Please list the name(s) of anyone that you authorize to have access to your healthcare and account information at Zilkha Radiology (Long Island MRI, PC/ Long Island Medical Imaging, PC/Long Island Medical Diagnostic Imaging, PC). If no names are listed you will be the **only** person we will discuss your healthcare and account information with.

1) _____ Relationship to Me: _____

2) _____ Relationship to Me: _____

3) _____ Relationship to Me: _____

4) _____ Relationship to Me: _____

Print Patient Name: _____

Patient or Legal Guardian Signature _____Date_____