ZILKHA RADIOLOGY

Long Island Magnetic Resonance Imaging, P.C.
Long Island Medical Imaging, P.C.
Long Island Medical Diagnostic Imaging, P.C.

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.

HIPPA ACKNOWLEDGEMENT

The HIPPA 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 Signature: ______________________________ Date: ________________

------------------------OR---------------------------------

Print Authorized Representative Name: ____

Relationship (parent, legal guardian, power of attorney): ______________________________

Authorized Representative Signature: ______________________________ Date: ______________