

I attest that the information above is correct to the best of my knowledge. I give consent to the examination ordered by my physician. According to the information above, I acknowledge that I have given this facility the right to file my insurance for payment of services rendered and I agree to pay any remaining balance of the account after my insurance has paid or denied payment. I understand that I must pay any coinsurance and/or deductible at time of service and that the quote for coinsurance and/or deductible is only an estimate. This information may be given to San Marcos Medical Imaging for payment of services rendered for the interpretation of the requested study. Therefore, San Marcos Medical Imaging will send a separate bill if there is an amount owed by you for the Radiologist fees. I authorize release of my medical information to and from physicians, nursing facilities, and/or other health care agencies to which I may be referred or transferred. I also acknowledge the Notice of Privacy Practices available in this office.

\*\*\*This is notification that certain services that are deemed necessary by your physician may not be reimbursed by your insurance company, including Medicare.\*\*\*

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document. I give permission to discuss my medical history with:

\_\_\_\_\_

Signature of Patient/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

**Female Patients:**

Is there a possibility that you might be pregnant? Yes/No

If so, estimated due date: \_\_\_\_\_

Are you breastfeeding? Yes/No

Date of last menstrual cycle: \_\_\_\_\_