The Radiology Clinic, LLC
Sign In

Name_____
Last First MI

Mailing Address _____

City_____ State _____ Zip _____

E-mail_____

Can we email you our monthly newsletter? ❒ Yes ❒ No

Date of Birth _____ Social Security # _____-_____-_____

_____ _____ _____
Primary Phone Secondary Phone Work Phone

Which should we call first? ❒ Primary ❒ Secondary ❒ Work

May we leave a voicemail or text message on your phone? ❒ Yes ❒ No

Date _____ Patient Signature _____

Insured's Place of Employment_____

Responsible Party (if other than patient)

Name_____
Last First MI

Mailing Address _____

City_____ State _____ Zip _____

Date of Birth _____

Acknowledgment of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices of The Radiology Clinic.

_____
Patient Name (Print)

_____ _____
Signature of Patient or Legal Representative Date

The Radiology Clinic

Medicare Part B

Extended Patient Signature Authorization

TO BE COMPLETED BY PROVIDERS OF SERVICE--Please PRINT or TYPE

Provider's Name	Provider's I.D. Code
THE RADIOLOGY CLINIC, L.L.C.	C017

Provider's Address *(Street, City, State, ZIP Code)*

208 McFARLAND CIRCLE N., TUSCALOOSA, AL 35406

Beneficiary's Name	Medicare HIC Number	Applicable MEDIGAP Group Number

TO BE COMPLETED BY BENEFICIARY OR AGENT--Directions For Payment Of Benefits And Release Of Medical Information

STATEMENT FOR PAYMENT OF MEDICARE BENEFITS

I request that payment of authorized Medicare benefits be made either to me or on my behalf to ***The Radiology Clinic, L.L.C.*** *(the Supplier) for any services or items furnished to me by the physician or supplier. I authorize any holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.*

.....

I request that payment of authorized MEDIGAP benefits be made either to me or on my behalf to ***The Radiology Clinic, L.L.C.*** *for any services furnished to me by the physician/supplier.*

STATEMENT FOR PAYMENT OF MEDIGAP BENEFITS

I authorize any holder of medical information about me to release to (name of MEDIGAP Insurer)

_____ *any information needed to determine these benefits or the benefits payable for related services.*

_____ _____

Signature of Beneficiary or person signing for Beneficiary — Date Signed

Address of Person Signing For Beneficiary (*Street, City, State, ZIP Code)*	Relationship Of Agent To Beneficiary

Reason Beneficiary Is Unable To Sign

IMPORTANT INFORMATION FOR PHYSICIANS

In submitting claims under this procedure, **PHYSICIANS undertake:**

1. To complete and submit promptly the appropriate Medicare billing form for all services covered by the request for payment--**even those in which the physician has not accepted assignment.**
2. To incorporate, by stamp or otherwise, information to the following effect on any bills they send to Medicare patients: **"DO NOT USE THIS BILL FOR CLAIMING MEDICARE BENEFITS. A CLAIM HAS BEEN OR WILL BE SUBMITTED TO MEDICARE ON YOUR BEHALF."** This requirement is necessary to prevent patients from submitting duplicate claims.
3. To cancel the authorization on request by the patient.
4. To make the patient signature files available for carrier inspection upon request.

IMPORTANT INFORMATION FOR SUPPLIERS

1. Only use this extended patient signature authorization for **assigned** claims.
2. Renew the patient signature agreement if a new item is rented or purchased.
3. Place alongside the beneficiary's signature the following statement: "RESPONSIBILITY FOR OVERPAYMENT ON ASSIGNED CLAIMS ACCEPTED."

The Radiology Clinic

Patient Authorization for Use and/or Disclosure of Protected Health Information

Patient Name:	Date of Birth:
Address:	Social Security or Account Number:

I hereby authorize The Radiology Clinic, LLC ("Radiology Clinic") to use, disclose and/or obtain the above-named patient's health information as follows (*check all that apply*):

□ **use the following health information maintained by Radiology Clinic until:**	□ **disclose the following health information to**:	□ **obtain the following health information from:**
_____ **Expiration Date/ will expire one year from signed date unless otherwise specified above.**	_____ **Address**:_____ **City, State, Zip**:_____ **Phone**:_____	_____ **Address:**_____ _____ _____

Specific description of the health information to be used/disclosed/obtained (*include dates of service, i.e., appointment date, type of service, etc):*_____
_____
_____

This health information is used/disclosed/obtained for the following purpose (*if Authorization requested by the patient put: "At the request of the individual"*): _____
_____

By providing this Authorization, I understand as follows:

1. **I understand that this Authorization may result in the sending of clinical information and x-rays with reference to the above-named patient's diagnosis and/or any alcohol, drug or child abuse problems, behavioral or mental health services, and/or information concerning sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency syndrome (HIV). I understand that these records are strictly confidential and are solely for the information of the person to whom addressed.**
2. I understand that this Authorization is voluntary. I may refuse to sign this Authorization and the above-named patient's treatment and/or payment obligations will not be affected unless either of the following applies:
   - The treatment is related to research and the use and/or disclosure is related to such research; or
   - The treatment is solely for the purpose of creating protected health information for disclosure to a third-party.
3. I understand that Radiology Clinic will not receive financial or in-kind compensation or remuneration in exchange for the use and/or disclosure of the above-named patient's protected health information unless an applicable legal exception applies.
4. I understand that the health information to be released may be subject to redisclosure by the recipient of the health information and no longer protected by federal or state law.
5. I understand that this Authorization is continuous in nature and is to be given full force and effect, including disclosing and/or utilizing any and all of the foregoing information learned or determined after the date hereof but prior to the expiration date noticed below.
6. I understand that I may revoke this Authorization at any time by notifying Radiology Clinic in writing, but if I do, it will not have any effect on uses or disclosures prior to the receipt of the revocation. Unless otherwise revoked, this Authorization will expire on _____ (date, event, or condition). If I fail to specify a date, event, or condition, this Authorization will expire in one (1) year.
7. I understand that, upon request, I may receive a copy of this Authorization form after I sign it.
8. I understand that a photocopy or facsimile of this Authorization shall be valid and effective, just as the original.

_____ _____
Signature of Patient of Patient's Representative Date

_____
Printed Name of Patient's Representative (if applicable)

_____
Representative's Relationship to Patient (if applicable)