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

208 McFarland Circle, North
Tuscaloosa, AL 35406
(205) 345-7000

TRICARE NON-COVERED SERVICES WAIVER

Date_____

Sponsor name_____ Relationship to patient _____

Sponsor ID#_____

Patient Name_____ Patient ID_____

Service Description _____

Procedure_____

Approximate Cost $_____

Date of Service_____

Provider Name: The Radiology Clinic, LLC

TIN: 63-0313602

Address: 208 McFarland Circle North, Tuscaloosa, AL 35406

I hereby affirm that I have been informed and I understand that these services are excluded or excludable under the TRICARE Program and therefore all costs associated with these services are not an allowable expense under the TRICARE program. By signing the TRICARE non-covered services waiver, I am hereby agreeing in advance, in writing, to accept full financial responsibility for all costs associated with the non-covered medical services, described in this document under "Service Description" and performed by the named Tricare Network Provider.

Patient Signature: _____ Date: _____

Beneficiary's or Legal Guardian's Signature: _____ Date: _____

Witness Signature: _____ Date: _____

TRICARE OPERATIONS MANUAL 6010.51-M, AUGUST, 1, 2002
CHAPTER 5, SECTION 1

2.5.1. A network provider may not require payment from the beneficiary for any excluded or excludable services that the beneficiary received from the network provider (i.e., the beneficiary will be held harmless) except as follows:

- If the beneficiary did not inform the provider that he or she was a TRICARE beneficiary, the provider may bill the beneficiary for services provided.
- If the beneficiary was informed that the services were excluded or excludable and he/she agreed in advance in writing to pay for the services, the provider may bill the beneficiary. An agreement to pay must be evidenced by the written consent of the beneficiary to pay for the excluded services. General agreements to pay, such as those signed by the beneficiary at the time of admission, are not evidence that the beneficiary knew specific services were excluded or excludable.
- If the beneficiary has been notified, in writing, that the service would not be covered for any reason.

For a list of excluded or excludable services refer to:
TRICARE POLICY MANUAL 6010.54-M AUGUST 1, 2002 CHAPTER 1 SECTION 1.1
ISSUE DATE: June 1, 1999 AUTHORITY: 32 CFR 199.4(g)

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)