ALLIANCE IMAGING

PATIENT CONSENT & ACKNOWLEDGEMENT FORM – MRI SCAN

This agreement allows Alliance Imaging, its Subsidiaries and Affiliates (Alliance Imaging) to bill Medicare, or any other insurance company providing benefits on your behalf, for diagnostic services performed by Alliance Imaging. In Medicare assigned cases, Alliance Imaging agrees to accept the Medicare "allowable charge" as the full charge.

I understand that my signature authorizes payment to be made directly to Alliance Imaging on my behalf for all payable benefits on any and all insurance policies that may be in force.

I understand that I am responsible for the payment of any patient liability including, but not limited to, deductibles, coinsurance or non-covered charges.

I agree to provide full written documentation of any dispute regarding charges for services provided by Alliance Imaging within seven (7) days of the date the service is provided to:

Alliance Imaging, Inc.

Patient Accounting Services

4825 Higbee Avenue, NW
Suite 201
Canton, OH 44718
(800) 762-4464
Fax: (330) 493-5376

Alliance Imaging's Notice of Privacy Practices (NPP) describes how your Protected Health Information may be used or disclosed as well as your rights related to the privacy of your Protected Health Information. You are encouraged to review our NPP and to understand your rights and the provisions of our NPP. Alliance Imaging welcomes any NPP-related questions you may have.

My signature below acknowledges that I have been offered a printed copy of Alliance Imaging's Notice of Privacy Practices. My signature does not necessarily indicate that I have reviewed the content of the NPP or that I have accepted its provisions.

Magnetic Resonance Imaging (MRI) forms pictures of the body by positioning it within a magnetic field. Radio signals are transmitted into the tissues, and a computer records the "echoes" which return. The pattern of these echoes is made into a picture of the body's internal structure. Magnets may attract metal objects both within or outside of the body and cause malfunctions of electronic or mechanical implants.

My signature indicates that I have been informed that I <u>will be excluded</u> from undergoing an MRI study if I have one or more of the following:

- Neuro pacemaker
- Cardiac Pacemaker
- Implanted chemotherapy pump
- Cochlear Implant

I have been informed that I <u>may be excluded</u> from undergoing an MRI study due to the presence of one or more of the following conditions with respect to my body:

- Brain Aneurysm Clips (suspected)
- Dermal Treatment Patches
- Pregnancy
- Body Jewelry

I waive all claims for magnetic damage done to items left on my person during this study (e.g. wallet, watch, credit cards, etc.).

My signature below indicates that I wish to proceed with a MRI study.

_____ Date: _____
Signature of Patient or Patient's Legal Representative

_____ Relationship to Patient _____
Print Name of Legal Representative if applicable

Initials/Location_____ **Patient ID/MR#_____**