CONSENT FOR SERVICES & AGREEMENT TO PAY

Patient Name_____ Date of Birth_____

AUTHORIZATION FOR TREATMENT:
I authorize BIOTECH X-RAY, INC. to provide treatment to the above named patient or myself.

NOTICE OF PRIVACY PRACTICES:
I have been given a copy of BIOTECH X-RAY, INC. Privacy Practices in compliance with HIPAA legislation.

ASSIGNMENT OF BENEFITS:
I authorize my insurance company to pay and hereby assign directly to BIOTECH X-RAY, INC., all benefits, if any, otherwise payable to me for services. Either my insurance company or I may revoke this authorization at any time in writing.

CANCELLATION OF APPOINTMENTS
I understand that I must give a 24-hour notice to cancel my appointment. I further understand that future services may be denied if I fail to keep my scheduled appointments.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION:
I authorize release of copies of pertinent medical records to providers outside of BIOTECH X-RAY, INC. who are being consulted with and/or I am being referred to in connection with my current treatment, to insurance companies for the purpose of determining benefits for services provided, and to reference laboratories for billing purposes.

PAYMENT AGREEMENT/COLLECTION POLICY:
I, the undersigned, do hereby expressly guarantee payment of all charges for medical services rendered, or to be rendered by BIOTECH X-RAY, INC. I understand that it is my responsibility to provide BIOTECH X-RAY, INC. with current insurance information. I understand that a finance charge of 1.5% per month is charged to any balance 60 days or older on my account. I will be responsible for the balance due, plus any costs that are incurred by BIOTECH X-RAY, INC. in collecting my account.

USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION
●My insurer may share my past, current and future health and account records with BIOTECH X-RAY, INC. about services I've received from BIOTECH X-RAY, INC. and other care providers unrelated to BIOTECH X-RAY, INC. These records may be used by BIOTECH X-RAY, INC as needed to manage or coordinate my care and to improve the quality of that care. If I do not agree to this, I will initial below.

●_____My insurer **MAY NOT RELEASE** any of my identifiable health records from providers unrelated to BIOTECH X-RAY, INC. for the purposes described above.

By signing this form, I am consenting to treatment and agreeing to these policies. I understand this authorization will remain in effect until I revoke it in writing.

_____ _____ _____
Date Signature Patient (if 18 yr.) / Parent / Legal Guardian Relationship to Patient