



PATIENT ASSIGNMENT OF BENEFITS

PATIENT INFORMATION

Name:		
DOB:	Gender:	Age:
Street Address:		
City:	State:	Zip:
SSN:	Phone Number:	

PROVIDER INFORMATION

Memorial MRI & Diagnostic, PLLC is a provider of diagnostic imaging and pain management services through itself and its wholly owned subsidiary Complete Pain Solutions, PLLC (collectively, the “Provider”). The Provider operates under the following trade names: **MEMORIAL MRI & DIAGNOSTIC, PRIME DIAGNOSTIC IMAGING AND FOUNDATION PHYSICIANS GROUP.** The Provider’s corporate headquarters is located at 11740 Katy Freeway, Ste 1300, Houston, TX 77079.

AUTHORIZATION FOR TREATMENT

I hereby consent to treatment by the attending physician and other medical staff for all diagnostic imaging, local anesthetics, test, surgical and other medical procedures as deemed necessary by myself, and the medical staff received today or in the future.

AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby agree to pay and assign to the Provider, those benefits, which may include settlement or judgement proceeds, if I have an attorney acting as an agent on my behalf, (the “Benefits”), otherwise payable to me by any third party as reimbursement of expenses and fees in connection with treatment rendered. I request that payment of authorized Benefits be made directly to the medical provider, third party, or their assigns, on my behalf.

FOR PATIENTS USING INSURANCE OR CASH AS PAYMENT FOR SERVICES RENDERED

I FULLY UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY AND ALL AMOUNTS NOT OTHERWISE PAID BY MY INSURANCE CARRIER OR ANY THIRD PARTY.

FOR PATIENTS USING A LETTER OF PROTECTION AS PAYMENT FOR SERVICES RENDERED

I AGREE THAT IF I HAVE AN ATTORNEY REPRESENTING ME, I WILL COOPERATE WITH ACTIONS THE ATTORNEY TAKES, AS PER HIS OR HER LEGAL AND ETHICAL DUTIES, RELATED TO PAYMENT FOR MY TREATMENT FROM SETTLEMENT OR JUDGMENT PROCEEDS. I FURTHER AGREE THAT ANY PAYMENT OWED TO THE PROVIDER FROM SETTLEMENT OR JUDGEMENT PROCEEDS MUST BE PAID IN FULL AND WILL NOT BE WAIVED OR REDUCED WITHOUT THE PROVIDER’S WRITTEN CONSENT. I UNDERSTAND THAT IF THERE IS A DISPUTE IT WILL BE ENFORCED IN THE COUNTY AND STATE WHERE I RECEIVED TREATMENT. I certify the accuracy of the information about me and authorize its release to the Health Care



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Finance Administration or other health care coverage entity, any information needed for this or any related health care claim that I provide in writing or verbally. I further understand and agree to pay for services or amounts due when appropriate. These charges could include amounts applied to my annual deductible co-payment amounts, charges denied as not covered by my insurance program or deemed medically unnecessary, and charges not satisfied through legal processes. I understand that well care is not covered by Medicare or many other health insurance programs.

I authorize release of information, digital films and images, and copies pertinent to my medical history and for follow-up of my positive findings. This consent authorizes the Provider to release to my insurance company, referring physician, and other physicians participating in my care, or attorney's representing me, my medical records, including images and reports.

I understand that if I have provided a wireless phone number that I agree to receive phone calls and text messages for appointment reminders and notice of my financial responsibility for treatment provided.

If someone other than the patient is signing this authorization, please state the relationship with patient and the reason patient is unable to sign.

I HAVE REVIEWED AND VERIFIED THE INFORMATION ABOVE AND I AM IN AGREEMENT WITH THE REPRESENTATIONS I HAVE MADE.

Patient Name