SPRING HILL IMAGING CENTER, LLC

A. **CONSENT TO TREATMENT**- I consent to routine diagnostic procedures and medical treatment provided by physicians and/or employees of Spring Hill Imaging Center, LLC.

B. **RELEASE OF INFORMATION**- I authorize that Spring Hill Imaging Center, LLC may give the information it possesses to treating and/or consulting healthcare providers and staff. Spring Hill Imaging Center, LLC, physicians, and other medical providers may disclose all or any part of the patient's medical record to any person or entity which is or may be liable for payment of any of the charges of Spring Hill Imaging Center, LLC and/or other medical providers, including insurance companies, medical or hospital service companies, and worker's compensation carriers, as well as to employers for worker's compensation-related treatment and employer-sponsored testing/exams (e.g. employment-related drug and alcohol testing, screening exams, etc.). If discharge planning for post-hospital care is prescribed, I authorize that the patient's medical information be transmitted to the post-hospital facility. I certify that the information given by me in applying for payment under Title XVIII or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about the patient to release to the Social Security Administration, or its intermediaries or carriers, and information needed for this or a related Medicare/Medicaid/Tenncare claim.

C. **AUTHORIZATION TO PAY INSURANCE BENEFITS AND FINANCIAL GUARANTY**- I hereby authorize direct payment to Spring Hill Imaging Center, LLC and other medical providers of all health, hospitalization, and other insurance benefits and assign and transfer all benefits that I am entitled to or otherwise are due to me or my estate. In exchange for the services given to patient, I agree that I am responsible for the payment of the account. I am liable according to the regular rates and terms of Spring Hill Imaging Center, LLC and other medical providers, and the same is payable to Spring Hill Imaging Center, LLC and other medical providers. I understand that the obligation to pay Spring Hill Imaging Center LLC and other medical providers is primarily on the patient (and /or the personal representative). While insurance or Medicare/Medicaid/Tenncare proceeds received by Spring Hill Imaging Center, LLC and other medical providers will be applied to the patient's account, any part of the account not paid by insurance will be owed by the patient (and/or the personal representative) as allowed by law, including any costs of collection, attorney's fees, and court costs.

D. **ADDITIONAL CONSENT**- I understand that, on rare occasions, it may be necessary to test the patient's blood to protect against possible transmission of blood-borne disease such as Hepatitis B or Acquired Immune Deficiency Syndrome. Results of this testing, when performed, will be kept strictly confidential.

Patient's Signature (or Representative) for Consent to Treat/
Release of Information/Financial and Additional Consent X_____
Date

_____ _____
Witness (Signature) Date Witness (Printed) Date