General Consent

I hereby direct Zoom Diagnostic Imaging, its agents and employees to follow the instructions and directions of my referring physician. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to results of treatments, tests or examinations.

Guarantee of Payment:
In consideration for the services to be provided to the patient, the undersigned promise(s) to pay Zoom Diagnostic Imaging all amounts legally due and not paid by Medicare, a third party payer, or other source on my behalf for services so rendered, which payment shall be due in full at the time of service. Additionally, I authorize and assign the DIRECT PAYMENT to Zoom, of any sum I owe or hereafter owe to be made by my attorney out of the proceeds of any settlement of my case, and by an insurance company obligated to reimburse me for the charges for Zoom services or otherwise obligated to make payment to me based in whole or in part upon charges made for Zoom services. In the event it is necessary to refer this account to a collection agency or an attorney, the undersigned further agrees to pay all reasonable costs of collection, including reasonable attorney fees. If more than one individual executes this agreement their liability shall be joint and several.

Assignment of Benefit, If Applicable:
In consideration for the services rendered or to be rendered, I hereby irrevocably assign and transfer to Zoom, all rights, title and interest, to the benefits payable by any and all third party payers that are or may be liable for the services rendered, to the patient. This irrevocable assignment and transfer shall allow Zoom to pursue any such right of recovery. Even though I have made this assignment, I understand that Zoom has the right to demand payment in full from me and the liability shall remain joint and several as between myself and all guarantors and third party payers, and I am responsible for payment for any charges not paid for me on my behalf.

Medicare Assignment of Benefits, If Applicable:
I hereby assign Zoom any Medicare or Medicaid benefits which may be available to pay for those services provided by Zoom. I certify that the information given to me in applying for payment under Title XVII of the Social Security Act is true and correct.

Authorization to Release Information, If Applicable:
The undersigned hereby authorizes Zoom to release information to: • The insurance company of record • Medical Assistance programs (induding their agents, reps or assignees) • The Social Security Admin or its intermediaries • 3rd party payers

Personal Valuables:
Zoom does not accept any responsibility for money, articles of apparel, jewelry, dentures, eyeglasses, hearing aids, or any valuables or belongings brought with any patients or patient's associates to Zoom .
**The undersigned certifies that he/she has read & fully understands the above paragraphs; and further certifies that he/she received a copy thereof, and is the patient or is legally authorized to act as a patient's agent to execute this document and accept its terms. I further recognize & accept that any & all physicians, who furnish services to the above named patient during this examination, are independent contractors & are not agents or employees of Zoom.

HIPAA Acknowledgement of Receipt of Zoom Diagnostic Imaging Notice of Privacy Practices
This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (PL.104-191), 42 U.S.C. Section 1320d, et. Seq., and regulations thereunder, as amended from time to time (collectively referred to as "HIPAA")

This authorization affects your rights in the privacy of your personal healthcare information. Please read carefully before signing.

By signing this authorization you acknowledge and agree that Zoom ("Practice") or its Business Associates may use or disclose your Protected Health Information (PHI) for the purpose of providing treatment, for purposes relating to the payment of services rendered, and for the Practice's general healthcare operations purposes. For purposes of this consent, "Protected Health Information" means any information, including your demographic information created or received by the Practice, that relates to your past, present, or future physical or mental health or condition.

Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand Practice's HIPAA Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While the Practice has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available and can be received by sending a written request with return address to the center where you were seen. By signing below, you are acknowledging that you have received, reviewed, understand and agree to the Notice of Privacy Practices, which describes the Practice's policies and procedures regarding the use and disclosure of any of your Protected Health Information created, received or maintained by the Practice.

Acknowledged and agreed to by:

_____ _____

Patient Signature Date