ORTHOPAEDIC SPECIALTY GROUP, P.C.

Exceptional People. Exceptional Care.

INSURANCE DISCLOSURE, PAYMENT AGREEMENT, AUTHORIZATION FOR RELEASE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION AND RELEASE OF MEDICAL RECORDS FILMS AND CD'S

I_____(Please print full name)
Understand that it is my responsibility to provide accurate and current demographic and financial information on the date of service. If I do not provide a copy of my insurance card on the date of service, I will be responsible for payment of medical services provided. I also understand that I am personally responsible for payment of medical services rendered should insurance coverage be declined or denied by my insurance provider as a result of any delay in providing correct insurance information/billing information.

I authorize the release of Records; CD's or Films, to my physicians, for diagnosis, treatment and reimbursement for services.
I also understand that if I require a CD of my imaging I will be charged a fee to cover the cost of materials: $6.00 for CD pick up, and $10.00 for mailed CD. Please provide 48 business hours to process CD pick up. Mailed CDs can take up to 7-10 business days.

The signature below also indicates I have either reviewed or received a Notice of Privacy Practices. I authorize OSG MRI to use or disclose my Protected Health Information (PHI) in any manner outlined in their Notice of Privacy Practices

Signature: _____ **Date:** _____

(Relationship: Patient, Parent, Guardian) _____