HEALTHCARE CONSENT AND AUTHORIZATION

Patient Name:_____**DOB:**_____

PLEASE READ AND INITIAL THE FOLLOWING:

_____ **CONSENT FOR MEDICAL TREATMENT:** I authorize the above-referenced center to provide the necessary diagnostic procedure(s) that have been ordered by my/the above-named patient's treating physician. I am aware that the practice of medicine is not an exact science, and I acknowledg that no guarantees have been made as to the results of diagnostic procedure(s) to be performed for me/the above-named patient in the above-referenced center. I understand that any questions related to my/the patient's care should be directed to the ordering physician. By law, I understand that if there is an at-risk exposure to my/the patient's blood or body fluids, I/the patient may be tested for HIV, Hepatitis B, or Hepatitis C virus. Those test results will be shared with the healthcare employee who was exposed. By initialing, I confirm that I have discussed the treatment with th ordering physician and have had the opportunity to ask questions, that I have been informed by the ordering physician of the alternative treatments, related risks, complications, and benefits, and that I accept the risks, complications, and benefits and authorize the above-referenced center to perfor the diagnostic procedure(s).

_____ **PREGNANCY WAIVER:** Is there any possibility that you/the patient could be pregnant? ___Yes ___No

_____ **PERSONAL BELONGINGS:** I/the patient am/are personally responsible for all belongings and/or valuables that I/the patient have/has in the cent and/or leave/leaves in the locker/dressing room or exam room. I will personally make sure that I/the patient have/has everything before leaving the premises.

_____ **ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY:** I hereby assign and authorize payment directly to the above-reference center of any and all medical benefits applicable to and otherwise payable for the services rendered by the center to me/the above-named patient. I hereby appoint the above-referenced center as the attorney-in-fact to take measures as may be necessary to collect any such payment. I understand that I am responsible for any deductibles and co-insurance at the time of the appointment. I understand that I am also financially responsible to the center for charges not covered by this assignment and hereby guarantee payment of all charges related to the services rendered to me/the above-named patient. I also understand that the facility is filing the insurance claim as a courtesy to me and that I am responsible for payment of this claim regardless of whether such services are covered by insurance. I agree to assist the center with the filing of insurance claims, as requested, and understand that my failure to timely provide the center with accurate information may result in the denial of the insurance claim. In the event my/th patient's account is placed with a collection agency or attorney upon default of payment, I agree to pay all collection costs, including, but not limitec to, late fees, attorney fees, and court costs.

_____ **AUTHORIZATION FOR RELEASE OF INFORMATION:** I hereby authorize the center to release any information requested by a third-party payor or other financially responsible party necessary to collect benefits or payment on claims for services rendered. Unless noted below, this authorization includes, but is not limited to, the release of information related to drug, alcohol, HIV antibody and/or psychiatric testing. I further authorize any physician or institution that treated me/the patient previously to furnish medical records or information that may be requested by the above-referenced center in connection with my/the patient's treatment. I permit a copy of this authorization to be used in place of the original.

_____ **AGREEMENT TO ARBITRATE**: In the event of any action being brought by either party hereto, it is understood and agreed that the laws of the State of Alabama shall control and govern. To that extent, and although not a condition precedent to receiving treatment, the parties herewith agree to arbitrate any and all disputes which may arise. RW Barnett Radiology PLLC, Southern Radiology Specialists PLLC, Dr. Ross W. Barnett, Birmingham Physicians' Radiology PLLC, Bluewater Radiology PLLC, Central Alabama MRI LLC, Central Alabama CT Imaging LLC, Dothan Diagnostic Imaging Radiology PLLC, Fort Payne MRI LLC, IMI Radiology PLLC, Open MRI Jackson Radiology PLLC , their employees, officers, directors, owners, members, shareholders, parent or affiliated corporations or DBA Entities, partners, heirs, successors, agents and assigns (hereinafter the "Barnett Parties") and Patient agree to submit any and all disputes between or among them to binding Arbitration which Arbitration shall be held in Jefferson County, Alabama. In the event Patient should initiate litigation (as opposed to Arbitration), Patient shall pay any and all costs and expenses in connection with such litigation and the Barnett Parties enforcing Arbitration hereunder which costs and expenses shall include, but not be limited to, any and all Attorney's fees incurred by the Barnett Parties in connection with the same. Inasmuch, notwithstanding anything herein contained to the contrary, in the event of litigation or Arbitration arising out of the interpretation or enforcement of the rights or obligations under this Agreement, the Barnett Parties shall be entitled to recover their costs and expenses in connection with such litigation or Arbitration including, but not limited to, any and all Attorney's fees incurred by it in the event it is the successful party. Notwithstanding any other provision contained herein to the contrary, however, Patient specifically agrees that any claims brought by the Barnett Parties for collection of monies owed for services performed hereunder shall not be subject to arbitration so long as the same are brought in the District Courts of Alabama and do not exceed $20,000.00.

_____ **HIPAA NOTICE OF PRIVACY:** I have received the notice of privacy practices of the above referenced center.

I hereby certify that I have read and fully understand the above consent and authorization.

SIGNATURE (Patient or, if minor, Signature of Patient's Representative)	**DATE**
PRINTED NAME OF PATIENT'S REPRESENTATIVE AND DESCRIPTION OF RELATIONSHIP TO PATIENT (if applicable):	