SOUTH JERSEY RADIOLOGY ASSOCIATES

Consent for Treatment

I hereby consent to any medical services rendered by the physicians, employees, and contracted healthcare providers of **South Jersey Radiology Associates, P.A.**

Communications Consent

I authorize Provider, its representatives, agents, and third-party vendors, to contact me using live agents, voicemails, pre-recorded messaging, auto-dialed calls, e-mails, and text messages to any phone number (including wireless numbers) or e-mail address provided or associated with me or my personal representative in connection with any matter relating to my treatment, payment, or account, including but not limited to scheduling, appointment reminders, billing, payment, collections, patient surveys, and information about products or services that may be of interest to me. I authorize Provider, its representative, agents, and third-party vendors to send me unencrypted messages using these means of communication. Providing this consent is not a condition of receiving medical treatment or services. I understand that I can also decline to receive further communications by following opt-out instructions as provided.

I hereby authorize Provider to disclose/release my medical information *(Including, Reports, Images, Results and Financial Activity)* to:

_____ Relationship: _____
(Please Print) *(Please Print)*

_____ Relationship: _____
(Please Print) *(Please Print)*

Assignment of Insurance Benefits & Authorization to Pay

I understand, Provider will bill my insurance carrier directly. I hereby assign, transfer, and give Provider all rights, title, and interest to medical, automobile personal injury protection, or workers compensation medical insurance benefits, and all other rights and privileges otherwise payable to me for those services provided. I also understand that obtaining precertification, authorization, or meeting other requirements or conditions of my insurance coverage is my responsibility.

Benefits Estimation & Financial Responsibility

I understand that Provider will collect the estimated patient financial responsibility at the time of service. Any payment collected today **represents an estimate** of the cost-share for services provided. I understand that I may owe additional funds, as my insurance company determines after it has processed my claim. If my insurance carrier denies coverage, I agree to be responsible for all additional funds, including a deductible, coinsurance, copayments, or the entire bill.

Self-pay patients will be asked to pay in full at the time of service. We accept all forms of payment. Please note that past-due accounts will be turned over to a collection agency if the invoice is not paid in full within 120 days from the date of your first statement. You may make payments online at (sjra.com). If you require financial assistance or a payment plan, please call 833-269-8008. Provider may apply payments received to any outstanding balance. Patients will be financially responsible for any returned check fees.

HIPAA Notice of Privacy Practices & Patient Rights

I acknowledge that I have been offered a copy of the Provider's Notice of Privacy Practices, and provided a copy of the Patient Rights.

I certify I have read the foregoing and understand its terms, and as the patient or as a duly authorized representative of the patient, I accept the above terms.

_____ _____
(Signature of patient/authorized representative) *(Print Name of patient/authorized representative)*

*Date:*_____