ADVANTAGE

MRI

Excellence in High Field Imaging

Assignment of Benefits, Release of Medical Records and Billing, and Insurance Authorization

I, _____, assign any and all rights and benefits under my policy to Advantage MRI, 600 North Tustin Avenue St. #100, Santa Ana, CA 92705.

I ask that any and all checks due to me under my policy be made out to the facility listed above. If my policy has a prohibition of assignment clause and does not allow assignment of benefits under the policy, then I instruct my insurance company to make the check payable to me but mail the check to the address mentioned above. Any failure to comply with the assignment will be a violation of Insurance Code Section 790.03 and Insurance Regulation and will be considered a violation of my rights under the policy.

Authorization to Release Information

I hereby authorize Advantage MRI to 1) release any information necessary to insurance carriers regarding my illness and treatments: 2) process insurance claims generated in the course of examination or treatment: and 3) allow a photocopy of my signature to be used to process insurance claims for the period of a lifetime.

I have requested medical services from Advantage MRI on behalf of myself and /or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fee are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation if the appropriate statement. A photocopy of this assignment is to be considered as valid as the original. The payment under the policy should be mailed to my provider at once and no unnecessary delays are acceptable.

I hereby authorize and direct my Insurance carrier to pay directly to Advantage MRI any benefits due to me under my insurance plan. I agree to pay the balance of expenses not paid under this plan, regardless of the Provider's contractual agreement with the Insurer. I authorize Advantage MRI to release to my insurance carrier any medical information necessary to process my claim.

Point of Service Patients: I understand that I may be responsible for an additional co-pay if I have gone "Out of Network" (according to individual plan guidelines).

Power of Attorney

The above health care provider is hereby given the power of attorney by the undersigned to sign my name on any checks for payment for services rendered by Advantage MRI. I also immediately rescind and void any and all other assignments received by my insurance company, including my attorney, in connection with healthcare services received in the office mentioned above.

Signature_____ Date:____/____/_____

Print name_____