CONSENT FOR TREATMENT

Authorization to Release: I hereby authorize Southern Diagnostic Imaging and any physician providing treatment to me, to release or disclose to insurance companies and/or outpatient benefit programs and their designees all information from my medical record pertaining to my medical treatment as needed to process insurance claims.

Authorization to Pay Insurance Benefits: I hereby assign payment directly to Southern Diagnostic Imaging of all insurance and similar benefits otherwise payable to me by virtue of medical treatment provided by Southern Diagnostic Imaging, but not to exceed Southern Diagnostic Imaging's regular charges for medical treatment. **I understand and agree that I am financially responsible for charges not covered by insurance, regardless of the status of medical insurances or similar benefits.**

Consent for Retirement of Medical Records: The undersigned authorizes Southern Diagnostic Imaging to retire medical records after seven years of no chart/billing activity.

Valuables: The undersigned hereby releases Southern Diagnostic Imaging and/or its staff of employees from any responsibility due to loss or damage of any valuables that the patient keeps in his/her possession or that may be brought by other persons while on the premises of Southern Diagnostic Imaging.

_____ **Financial Agreement: Payment is due at the time of service.**

(Initial) For services rendered to the patient named below. I the undersigned, agree to pay all professional, outpatient and/or collections fees necessary for the collection` of payment.

Patient Name	**Signature**	**Date**