X-RAY ASSIGNMENT AGREEMENT AND CONSENT

I understand that my doctor is submitting my x-rays to Radiology Diagnostics, LLC for primary radiological interpretation and report by a specialist. I also understand that the fee for such services will be submitted to my insurance company, healthcare carrier, attorney or worker's compensation carrier for payment. If I am paid directly by an insurance carrier or through a legal settlement, I will be responsible for the amount paid. If Radiology Diagnostics LLC does not receive payment for services rendered, I understand that I am fully responsible for payment. If Radiology Diagnostics, LLC does not receive a lien, or if Radiology Diagnostics does not receive a reply to a case status information request from my attorney, I will be billed for the amount of service. Once Radiology Diagnostics, LLC receives a reply from the attorney I will stop being billed.

I also give my consent to Radiology Diagnostics, LLC's use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes.

I understand that I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment, or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I have the right to revoke this consent, in writing, at any time, except to the extent that the Practice has acted in reliance on this consent. I acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Radiology Diagnostics, LLC, which describes the Practices policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received, or maintained by the Practice. **My Signature authorizes the release of medical information to:**

Radiology Diagnostics, LLC
P.O. Box 130
North Easton, MA 02356

In the event my insurance company or attorney sends payment of services to me, I agree to promptly remit such payment to Radiology Diagnostics, LLC

_____ _____

Date **Patient Signature**

_____

Print Patient Name

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Parent or Guardian Signature