Columbus Diagnostic Center
Assignment of Benefits/Authorization for Treatment

● **CONSENT FOR MEDICAL TREATMENT:** I authorize Columbus Diagnostic Center to furnish the necessary medical or surgical treatment or procedures, including diagnostic, x-ray, and drugs and supplies as may be ordered by the physician(s), his assistants or his designees. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of my treatment. I recognize that the physician practicing at Columbus Diagnostic Center is not employed as such, but is an independent radiologist. Columbus Diagnostic Center may delegate to this physician those services physicians normally provide; and any questions relating to the care my physician has given or ordered should be directed to him/her.

● **ASSIGNMENT OF BENEFITS:** I hereby authorize payment directly to Columbus Diagnostic Center of any and all medical benefits applicable and otherwise payable to me. I understand that I am financially responsible to Columbus Diagnostic Center for charges not covered by this assignment.

● **AUTHORIZATION FOR RELEASE OF INFORMATION:** I hereby authorize Columbus Diagnostic Center to release any information, including information regarding diagnosis and treatment requested by the insurance company, necessary to collect benefits under the policies started at the time of treatment, or any policies which I subsequently make claim against for hospital services, including related physicians' services on this or related dates of services. Unless noted below, this authorization includes, but is not limited to, the release of information related to drug, alcohol, HIV antibody and/or psychiatric treatment and/or testing. **Withhold from release:** _____ I further authorize any physician or institution that attended me previously to furnish medical records or information which may be requesting by Columbus Diagnostic Center or the attending physician.

PATIENT ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

I have received a copy of the Notice of Privacy Practices of Columbus Diagnostic Center on the date indicated below. I understand that if any changes are made to this Notice of Privacy Practices, a revised copy of the Notice will be posted in the offices of Columbus Diagnostic Center. I also understand that if I wish to receive additional copies of this Notice of Privacy Practices in the future or if I have any questions with regard to this notice of Privacy Practices, I may contact:

Columbus Diagnostic Center
2040 10th Avenue
Columbus, Georgia 31901
706-322-3000

X _____ _____

Signature of Patient | Printed Name

Date: _____

Tricare/Underage Patients

TRICARE/CAMPUS - Patients Only

I understand that Tricare is secondary to other insurance plans except for Medicaid and Tricare supplement plans. I agree to provide Columbus Diagnostic Center with all insurance plans that I am currently enrolled so that benefits can be coordinated and the appropriate authorizations can be obtained. I understand that failure to provide correct and accurate information may result in the patient in being responsible for entire balance.

_____ _____ _____

Patient/Guardian Signature | Witness | Date

- **PATIENT UNDER 18:** I hereby give my permission for _____ to be treated by Columbus Diagnostic Center.

_____ _____

Patient/Guardian Signature | Date