Hammers & Riccio Imaging, PLLC

Patient Acknowledgement and Financial Authorization

A. **CONSENT FOR TREATMENT**: I consent to being treated as a patient of **Hammers and Riccio Imaging, PLLC** ***(H&RI)*** for the purpose of receiving ultrasound services, ultrasound guided treatments and/or diagnostic procedures. I have the right to consent or to refuse any proposed procedure or therapeutic treatment, and that discussion of the risks, benefits and alternatives to each procedure or treatment is available to me. I understand that these images will be stored in a secure manner that will protect my privacy. Images that identify me will be released and/or used outside the institution only with *my written authorization* or that of my legal representative.

B. **AUTHORIZATION FOR PAYMENT/FINANCIAL AGREEMENT**: I agree to pay H&RI for all services and supplies provided to me, and for any other applicable charges. I authorize and direct my primary insurance carrier, health sharing ministry, discount plan or another entity ("Payor") to make payment to Hammers and Riccio Imaging PLLC of all insurance or other benefits, including authorized Medicare benefits, and assign my rights to H&RI. I have requested that H&RI first seek payment for the medical services provided from such Payor. I understand that by agreeing to do so, H&RI have not agreed to accept less than full payment of amounts due and owing from any such entity unless H&RI have an existing contract with such entity to accept reduced payment for the services provided.

   You will be asked to provide your insurance card(s) and picture ID at every visit. This is to ensure that the information we have on file is correct and that your plan is current. If there is a problem with your insurance, it is your responsibility to contact them and/or provide us with any information needed to help in the processing of the claim. *If you do not provide all the proper information, the full amount will be your responsibility*. Regardless of what my identification card says, I understand and agree that I may be billed, and will be obligated to pay, for any such amount not paid by my Payor, to the extent permitted by law. I agree to pay any remaining balance not covered by my insurance plan or not paid by any Payor. If I receive payment from my insurance company or other Payor for services provided to me by H&RI, I agree to submit the payment to H&RI.

   Your insurance REQUIRES that we collect your share of the payment. Refusal to pay these fees can result in inability to reschedule, cancellation of your future appointments, or ultimately sent to an outside collection agency. We accept Cash (exact amount), credit or debit cards and personal checks ($25 fee will be charged for any returned checks for insufficient funds). If my account is not paid, I will pay all costs incurred as a result of H&RI collection efforts, including, without limitation, attorneys' fees and court costs. As a courtesy, H&RI may assist me in processing insurance claims, however, H&RI accepts no responsibility for any processing procedures, acts, omissions, or neglect. Any amounts not paid by my insurer become due and payable when the bill is mailed or on demand. If my bill is not paid in full, H&RI reserve the right not to provide any future medical services to me.

   Should you prefer to charge your balance automatically after the insurance claim is processed, we will ask that you please leave a credit or debit card on file. Upon receipt of your insurance plan's Explanation of benefits (EOB), the full balance will be processed*.

C. **COMMUNICATIONS**: If I have provided a telephone number or email address as a contact, I hereby authorize H&RI, along with their respective employees, agents, and business associates, to contact me via phone, text message or email using any type of artificial or pre-recorded voice or autodialed technologies for any reason permitted by law, including, without limitation, automated notifications, and appointment reminders.

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D. **RELEASE OF INFORMATION**: I understand that H&RI can release all necessary health information for purposes of treatment, payment, and healthcare operations. I authorize the release any information of my medical record, to other treating providers and to third-party payers, including but not limited to insurance companies, managed care organizations, Medicare, Medicaid, and other governmental payors. I understand that H&RI may release any and all necessary information with respect to my treatment when required to do so by law.

I understand that refusal of consent to release my health information will not jeopardize my right to obtain present or future treatment, except where disclosure is necessary for the treatment. I understand that I may revoke this authorization at any time, in writing, except to the extent that action has been taken in reliance on it. The authorization provided in this Section C expires one year from the date signature. I understand that if I refuse to authorize release of information and this results in a refusal by my insurance company or other responsible payor to pay H&RI for my treatment, *I will be responsible for the entire unpaid portion of my bill*.

☐ **Accepts** ☐ **Declines** **Initials**: ________

E. **ACKNOWLEDGE OF RECEIPT OF PRIVACY PRACTICES**: I hereby acknowledge that I ca received (upon request) a copy of the medical practice's notice of Privacy Practices. I further acknowledge that a copy of the current policy is posted in the reception area.

F. **YALE HEALTH PLAN MEMBERS ONLY:** Yale University Health Services has requested that we provide them with a digital copy of your exams. The images will be stored in your secured medical record at the Health Plan. The purpose of this is to consolidate all your images to provide the clinicians with a complete record of your medical condition for treatment purposes.

Initials: ________

G. List of any person **(other than yourself and your physicians)** you give permission to speak with about your healthcare

Name	Relationship	Contact
Name	Relationship	Contact

By Signing Below, I acknowledge that I have read, understand and accept the policy.

►Patient Name: ________________________ ► Date of birth: _______/ _______/ ________
MM DD YYYY

►Legal Guardian: ________________________ ►Relationship: ________________
If Applicable

►Signature: ________________________ ►Today's date: _______/ _______/ ________
MM DD YYYY

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