CHEYENNE RADIOLOGY

I _____ have been advised that there are copies of the Notice of Privacy Practices of Cheyenne Radiology throughout in the reception area. This notice references how the use or disclosure of Protected Health Information will be handled by the practice. I further acknowledge that upon my request, I will be provided a written copy of this notice.

Responsible Party / Patient Signature:_____ **Date:**_____

Cheyenne Radiology will file a courtesy claim with your insurance carrier if you filled out the insurance information in detail and provided us with a copy of the front and back of your insurance card. If the account is self pay, payment arrangements must be made within 15 days of the date of the service(s) is provided. Further, I understand that filing an insurance claim does not guarantee payment to Cheyenne Radiology and that I am responsible for any balance my insurance claim does not pay. I authorize treatment of the person named above and agree to pay all fees and charges for treatment. I authorize release of medical information to insurance companies providing coverage for the above named patient.

Patient or Responsible Party Signature: _____

Please Print Name: _____ **Date:**_____