CHEYENNE RADIOLOGY

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

Consent for Treatment and Billing

Cheyenne Radiology Group 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 service(s) provided. Further, I understand that filing an insurance claim does not guarantee payment to CRG and that I am responsible for any balance my insurance claim does not pay. I authorize treatment of the person named and agree to pay all fees and charges for coverage for the patient.

Assignment of Benefits

I authorize direct payment to be made to the physicians of Cheyenne Radiology Group for any and all imaging services rendered. I also authorize the release of any medical records for the purpose of healthcare operations.

Patient's Printed Name: _____ **Date of Birth:** _____

Phone Number: _____ **Today's Date:** _____

Patient or Responsible Party Signature: _____

Because of the HITECH ACT, we are required to offer you access to our Patient Portal and show proof that we have offered it to you. On the Portal, you can access your records and reports from our office website. If you are interested, please enter your email address below. If you want to opt out, please sign the Opt Out option below.

Email Address: _____

OPT OUT Signature: _____