

Washington Imaging Services, L.L.C.
Patient Registration

Patient		Guarantor:
Patient Name:	DOB:	Name:
Street:	Age / Sex	Street:
City / State / Zip		City / State / Zip
Home phone:		Home phone:
Work Phone:		Relationship
Referring Physician:		Employer:
Patient Account #		Insurance:
Unit #		

CONSENT TO CARE AND FINANCIAL RESPONSIBILITY WHILE IN WASHINGTON IMAGING SERVICES, LLC

CONSENT TO CARE:

PERMIT FOR MEDICAL AND/OR SURGICAL TREATMENT: I, the undersigned, hereby consent to and permit Washington Imaging Services, LLC (WIS, LLC), their designees, and all other persons caring for me to perform and administer tests, examinations, including but not limited to x-rays, medical and surgical treatment and other procedures which may be deemed necessary or advisable for me. I am aware that the practice of medicine is not an exact science and acknowledge that no guarantees or promises have been made to me as to the result of the examination.

PERSONAL VALUABLES: It is understood and agreed that WIS, LLC shall not be liable for the loss or damage to any personal property including, but not limited to money, jewelry, glasses, dentures, documents, furs, or other articles of unusual value and small size, or any personal property including clothing, left unattended.

RELEASE OF INFORMATION: I hereby authorize WIS, LLC to disclose all or any part of my record, and any other information in WIS, LLC's possession, to any person or entity which is or may be liable for all or part of the charges related to my care, including, but not limited to worker's compensation carriers, insurance companies, welfare funds, or my employer. I hereby release WIS, LLC from all legal responsibility or liability which may arise from disclosure of my record to any insurer, its intermediary or another health care facility to provide continuity of care. I understand that WIS, LLC keeps a record of the health care services provided and that I may request to review my record (a 24 hour notification is required). Except as noted above, WIS, LLC will not disclose my record to others unless I direct it to do so or unless the law authorizes or compels it to do so.

FINANCIAL AGREEMENT:

PRIVATE PAY: The undersigned agrees, whether signing as agent or as patient to be financially responsible to Washington Imaging Services, LLC for charges not paid by insurance. I understand this amount is due upon billing.

INSURANCE COVERAGE: I hereby assign payment directly to Washington Imaging Services, LLC for benefits otherwise payable to me, but not to exceed the charges for service. Any portion of charges not paid by the insurance company will be billed to me and is then due and payable within 30 days of invoice. This is in addition to a charge for reasonable attorney fees, court costs, and collection agency expenses incurred to collect the amount due.

I CERTIFY THAT THE FOREGOING HAS BEEN EXPLAINED TO ME AND I HAVE READ AND UNDERSTOOD ITS CONTENTS. I ACKNOWLEDGE RECEIPT OF A COPY OF THIS FORM.

Signature of Patient (if not a minor) _____ Date _____ Time _____

The patient is unable to consent because: _____

Signature of parent, guardian or other _____ Relationship _____ Date _____ Time _____ Witness _____

Patient authorizes Washington Imaging Services, LLC (WIS) to obtain professional radiology interpretations from Overlake Imaging Associates, PC or it's designee (OIA), a separate entity. A portion of the WIS billing may represent fees due to OIA for OIA's services.