COMPLETE WOMEN'S IMAGING, PC
990 STEWART AVENUE, SUITE 100
GARDEN CITY, NY 11530
Phone: (516) 222-4294

ACKNOWLEDGEMENT OF DOCUMENTATION REVIEW

- **NOTICE OF PRIVACY PRACTICES (Copy Provided)**

BENEFITS ASSIGNMENT AND FINANCIAL RESPONSIBILITY

RELEASE OF INFORMATION: I authorize Complete Women's Imaging, PC and its providers to disclose and release to my insurance carrier(s), including Medicare, Medicaid, Medigap/Supplemental benefits providers, and private insurers, as applicable, any medical and treatment information needed for payment purposes for services rendered. I authorize use of this form for the release of information needed to process claims to all my insurance carriers(s) and its authorized agents. I authorize my provider/practice to act as my agent in helping obtain payment from my insurance companies. I understand it is my responsibility to provide current and accurate insurance information, including any updates or changes in coverage.

ASSIGNMENT OF BENEFITS: I assign all payments, rights and claims for reimbursement of claims, costs and expenses allowable under my insurance plan(s) directly to my provider or practice for services rendered. I understand I will receive a statement for any balance due by me and I agree to make full payment upon receipt of the statement after the insurance has met its obligation.

AGREEMENT OF RESPONSIBILITY: I understand that all copayments, deductibles, patient responsibility amounts and past-due balances are due at the time of check-in unless previous arrangements have been made with the billing coordinator. I understand that I am financially responsible for charges not covered by my insurance company.

MEDICARE LIFETIME AUTHORIZATION: If a Medicare beneficiary, I understand my signature requests payment to be made and authorizes release of medical information necessary to pay claims. If 'other health insurance' is indicated in item 9 of the HCFA-1500 Form, or elsewhere on approved claims forms, or electronically submitted claims, my signature authorizes the release of information to insurance companies or its authorized agents. In Medicare-assigned cases, the physician or supplier agrees to accept the charge of determination of the Medicare carrier as the full charge, and I agree I am responsible for copay, deductible, coinsurance and non-covered services. Copay, coinsurance and deductibles are based upon the charge determination of the Medicare carrier. I understand that this is a lifetime authorization and will remain in effect until further written notice from this patient. In addition, I permit a copy of this authorization to be used in place of the original.

I acknowledge that I have read and fully understand the documents listed above. I have been given the opportunity to ask questions and all of my questions have been answered fully and to my satisfaction.

X_____ X_____ X_____

Patient Signature Date Printed Name

_____ _____ _____

Parent/Guardian/Interpreter Signature Date Relationship if other than patient

_____

MRN#

COMPLETE WOMEN'S IMAGING, PC
990 STEWART AVENUE, SUITE 100
GARDEN CITY, NY 11530
Phone: (516) 222-4294

*The signature of the patient must be obtained unless the patient is an unaccompanied minor under the age of 18 or is otherwise incapable of signing.