

South County Imaging, LLC

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Patient Name: *(please print)* _____

I hereby acknowledge that I have received the Notice of Privacy Practices statement of South County Imaging, LLC.

Signature: _____ Date: _____
Patient or Legal Guardian

PAYMENT AGREEMENT

I hereby guarantee payment to **South County Imaging** of all charges incurred for this account. I understand that if my insurance company denies this claim, in whole or in part, payment for same will be remitted within ten (10) days of receiving notice.

Signature: _____ Date: _____
Patient or Legal Guardian

ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to **South County Imaging** for the insurance benefits to which I am entitled.

Signature: _____ Date: _____
Subscriber

Witness: _____

RELEASE OF PRIVATE HEALTH INFORMATION

I, _____, hereby give permission to **South County Imaging Center** to release information regarding my care to the following people:

<i>Name</i>	<i>Relation</i>
_____	_____
_____	_____
_____	_____
_____	_____