PATIENT NAME: ____

_______ASSIGNMENT OF BENEFITS: I hereby assign payment directly to Sugar Mill Diagnostic Imaging, L.L.C. by accepting this assignment, all medical benefits applicable, including Medicare, private insurance, and any other health plans otherwise payable to me will be paid directly to the aforementioned. I understand that I am financially responsible to Sugar Mill Diagnostic Imaging, L.L.C. for charges not covered by this assignment or for any and all charges, which the insurance carrier declines to pay. It is further agreed that any credit balances resulting from payment of insurance or other source may be applied to any other accounts owed by the insured or his/her family.

_______MEDICARE/MEDICAID INFORMATION RELEASE & PAYMENT AUTHORIZATION: I certify that the information given by me in applying or payment in accordance with the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration or its intermediary carriers any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for charge to Sugar Mill Diagnostic Imaging, L.L.C. I understand that I am responsible for any health insurance deductibles and coinsurance.

_______FINANCIAL AGREEMENT: The undersigned agreed, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she obligates himself/herself to pay the account of Sugar Mill Diagnostic Imaging, L.L.C. in accordance with the regular rates and terms. Should the account be referred to a collection agency and/or attorney for collection, the undersigned shall pay reasonable attorney's fees, collection expenses, and a returned check fee of $20.00 if applicable.

_______HMO DISCLAIMER: I certify that I am not presently enrolled in any Health Management Organization (HMO). Subsequent rejection of a claim as a result of this admission, due to enrollment in a HMO plan will constitute responsibility for payment of claim on my part at the currently established standard fee schedule.

_______INDEPENDENT PAYMENT FOR SERVICES: I request to pay for services independent of any insurance coverage or benefits. I understand that Sugar Mill Diagnostic Imaging, L.L.C. will not at any time file any insurance claim for these services on my behalf.

I authorize Sugar Mill Diagnostic Imaging, L.L.C. to release information acquired in my treatment to my insurance company. In addition, I authorize Sugar Mill Diagnostic Imaging, L.L.C. to request and obtain any medical reports necessary for comparison purposes associated with my treatment.

FLORIDA FRAUD STATUTE: The undersigned certifies that he/she has read the foregoing, and is the patient, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms. I also understand that any person who knowingly and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree, in violation of Florida Statute Section 817.234.

____ ___________________________

PATIENT SIGNATURE DATE

CONSENT FOR MINOR FOR DIAGNOSTIC IMAGING PROCEDURE (S):

____ ___________________________

SIGNATURE OF PARENT/GUARDIAN DATE