MULTI-PURPOSE AGREEMENT FORM

DIAGNOSTIC TESTING MEDICAL CONSENT
I consent to the administration and performance of all diagnostic procedures which, in the judgment of his/her physician/nurse practitioner that maybe considered necessary or advisable. I also agree that if I decide to leave without receiving treatment and/or without the consent of my physician, then Millennium Imaging will not be liable for any consequences of that decision.

CONSENT TO RELEASE OF FILMS
Original films are the property of Millennium Imaging Medical Center. Upon my request, Millennium Imaging will gladly release original films to serve my best interest. Once films are released to patient, or referring physician I understand that I will not hold Millennium Imaging Medical Center liable for all known or unknown claim(s) that may arise should the films are to be missing or lost. If the original films are lost, they can be duplicated at a cost of $15.00 per sheet or $25.00 per CD.

RELEASE OF INFORMATION & HIPPA CONSENT
In order to obtain reimbursement, I understand that portions of the my medical record, may be disclosed to any person or corporation (or any agent of such person or corporation) which will be affiliated for all or any portion of charges by Millennium Imaging Medical Center, Inc. (including, but not limited to, insurance companies, health care services plans, worker's compensation carriers and employers.) I hereby acknowledge that I may receive a copy of medical practice's Notice of Privacy Practices, at my request. I further acknowledge that a copy of the current notice will be available in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment by request.

ASSIGNMENT OF BENEFITS
I hereby authorize that any payment that is made payable to me from my insurance company will be forwarded to Millennium Imaging Medical Center, Inc. Payment shall not exceed the Millennium Imaging's regular charges for treatment. I understand that I am financially responsible to MIMC for charges not covered by my insurance carrier.

FINANCIAL AGREEMENT
In consideration of the services provided, I understand and agree that I am held financially responsible (undersigned may be patient, agent, or financially responsible party) for all charges, whether or not charges are covered by my insurance. In accordance with the medical insurance policy current rates and terms, all payments and/or balance owed must be forwarded and made payable to Millennium Imaging Medical Center, Inc. **(ALL DEDUCTIBLES AND COPAYMENTS ARE DUE AND PAYABLE AT THE TIME OF SERVICE.)** If it is necessary to utilize an attorney to enforce this agreement, or collect any judgment based upon this agreement then I will be financially responsible and liable for all court costs and attorney fees accrued, including bankruptcy court and appellate court.

AUTHORIZATION TO TRANSFER FUNDS
I understand should a credit balance appear on my account with Millennium Imaging Medical Center, Inc. then I authorize that use of credit balance may be applied to any unpaid balance due Millennium Imaging Medical Center, Inc. Furthermore, once all claims has been processed, I may receive a refund from Millennium Imaging Medical Center, Inc. for any excess of funds that was paid at the time of service prior to the submission of claim. All refunds are processed on the 1st and the 15th of the month.

Certification: I certify that I have read, agreed and accepted the above terms and condition and I may receive a copy of this agreement upon request.

_____Date _____
Patient, or patient's Agent or Representative

* If patient is a minor, the parent, a legal guardian, or a person authorized by them in writing must sign.
* If patient is incompetent, a legal guardian or conservator must sign.