BEMIS TUPMAN CHIROPRACTIC

X-RAY ASSIGNMENT AGREEMENT AND CONSENT

I understand I am responsible for the $30.00 Radiology fee required by Brookside Radiology. In a Personal Injury case, my insurance will be billed for the above amount. In the case my insurance does not pay, I will be responsible for the $30.00 fee.

I also give my consent to Brookside Radiology Inc. use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes.

I understand that I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purpose of treatment, payment or healthcare operations of the practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction is binding on the Practice.

I have the right to revoke this consent, in writing, at any time, except to the extent that the Practice has acted in reliance on this consent. I acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Brookside Radiology Inc., which describes that Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, or maintained by the practice. **My signature authorizes the release of medical information to:**

Brookside Radiology Consultants, Inc
P.O. Box 349
Buzzards Bay, MA 02532

In the event my insurance company or attorney sends payment of services to me, I agree to promptly remit such payment to Brookside Radiology Inc.

Patient Name: _____
Date of Birth: _____
Sex: _____
Referring Doctor: **Kristina Bemis Tupman**
Stephen Tupman
Christina Faccin-Rives

_____
Date

_____
Patient Signature

Description of Views:

_____
Print Patient Name

_____
Parent or Guardian Signature

Doctor Notes:_____