

# American Imaging & MRI

## Release & Responsibility

I authorize any insurance benefits be paid directly to the physician or facility. I authorize American Imaging & MRI or my insurance company to release any information required to process the claim.

I affirm that I will be responsible for any and all unpaid balances for services associated with treatment by this office, and that payment in full is due when services are rendered. I understand that billing my insurance company is a courtesy and that I am responsible for any outstanding balance when services are rendered. This includes my insurance company not being billed correctly and if the claim has not been submitted to the insurance company by the physician, facility, or their staff.

I will be responsible for any and all unpaid balances, collection costs, collection agency fees, and attorney's fees along with any other expenses which might be associated or incurred to collect the unpaid balance on my account.

Signature of Responsible Party: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_