

Battlefield Imaging  
4700 Battlefield Pkwy Suite 100  
Ringgold, GA 30736

**AUTHORIZATION FOR MEDICAL AND/OR SURGICAL TREATMENT**

PATIENT'S NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

The above named patient or authorized representative does hereby voluntarily consent to such hospital care encompassing routine diagnostic procedures and medical treatment as may be ordered by physicians responsible for such medical care. I further consent to treatment by authorized employees or agents of Battlefield Imaging, LLC who are assigned to the patient's care. I acknowledge that no guarantees have been made to me as to the results of treatments, examinations, or medical care performed at Battlefield Imaging, LLC.

**ACKNOWLEDGEMENT OF PHYSICIAN SERVICES:** The physicians providing treatment for me are not agents or employees of Battlefield Imaging, LLC, including but not limited to any radiologist, pathologist, anesthesiologist, or any type of specialist, is an independent contractor and is not an agent or employee of Battlefield Imaging, LLC. This is true even for physicians that may be assigned to you or provide service to you without your knowledge.

**CONSENT TO ANTIBODY TESTING:** In the event of an accidental exposure to blood or other body fluids through a needle stick, cut, mucous membrane contact, or the like, the undersigned consents to appropriate tests for the presence of the Hepatitis B virus and the antibody for Human Immunodeficiency Virus (HIV), which is the virus believed to cause AIDS (Acquired Immune Deficiency Syndrome). The patient will be informed of any positive results, and all such results will be treated as confidential.

**PERSONAL VALUABLES:** Battlefield Imaging, LLC shall not be liable for loss or damage to any money or valuables, including but not limited to jewelry, glasses, dentures, documents and other personal articles of value.

**ASSIGNMENT OF BENEFITS:** I hereby assign payment directly to Battlefield Imaging, LLC the insurance benefits otherwise payable to me for this period of outpatient care starting \_\_\_\_\_. I understand I am financially responsible to Battlefield Imaging, LLC for charges not covered by this assignment. I hereby authorize Battlefield Imaging, LLC to transfer any overpayment which I am responsible

**RELEASE OF INFORMATION:** I hereby authorize Battlefield Imaging, LLC to release to any insurance company or other potential third party payor any information requested by any such insurance company or potential third party payor when it is in anyway related to a request by Battlefield Imaging, LLC for a determination or verification of expense coverage or when it is related to the payment of a claim for payment expenses for my treatment at Battlefield Imaging, LLC.

**Date of Service:** \_\_\_\_\_

**MEDICARE PATIENTS: STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIAN, AND PATIENT.** I certify that the information given by me applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

**PROMISE TO PAY ACCOUNT: FOR AND IN CONSIDERATION OF SERVICES RENDERED AND TO BE RENDERED TO THE ABOVE NAMED PATIENT. I/WE JOINTLY AND SEPARATELY PROMISE TO PAY BATTLEFIELD IMAGING, LLC ALL ITS CHARGES FOR SERVICES RENDERED TO AND FOR THE ABOVE NAMED PATIENT FROM ADMISSION TO DISCHARGE.**

\_\_\_\_Yes \_\_\_\_No I hereby acknowledge receipt of a copy of the brochure entitled Your Right to Decide which summarized my right to make choices and to execute advance directives concerning medical treatment should I desire.

I have previously executed the following advance directives:

\_\_\_\_Yes \_\_\_\_No A living will \_\_\_\_\_Yes \_\_\_\_No A Durable Health Care Power of Attorney

If I have executed an advance directive I will provide a copy for my medical records.

This form has been fully explained to me and I certify that I understand its content. Your signature indicates approval of all of the above unless otherwise marked & indicated.

PATIENT/GUARANTOR SIGNATURE \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_ PATIENT'S MARK \_\_\_\_\_(if unable to sign)

WITNESS \_\_\_\_\_ DATE \_\_\_\_\_ TIME \_\_\_\_\_

REASON PATIENT IS UNABLE TO SIGN \_\_\_\_\_