

## Condition Of Admission

### 1. CONSENT TO MEDICAL TREATMENT

The undersigned consents to the exams which may be performed, including emergency treatment or services, and which may include but are not limited to general care and diagnostics testing.

### 2. RELEASE OF INFORMATION

The undersigned agrees that to the extent necessary to determine liability for payment and to obtain reimbursement, Santa Barbara Extremity MRI may disclose portions of the patient's record, including his/her medical records, to any person or corporation which is or may be liable, for all or any portion of Santa Barbara Extremity MRI's charges, including but not limited to insurance companies, health care service plans or workers' compensation carriers. The undersigned authorizes the release of medical records and/or information both to and from Santa Barbara Extremity MRI for the purpose of continued medical care and payment. The undersigned authorizes Santa Barbara Extremity MRI to act as a representative on his/her behalf to dispute payment or allowances which includes, but is not limited to, the pursuit of a claim, underpayment, or appeal of a denied claim from my insurance carrier.

### 3. FINANCIAL AGREEMENT

The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligated himself/herself to pay the account of Santa Barbara Extremity MRI in accordance with regular rates and terms of the facility. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorney's fees and collection expenses. All delinquent accounts may bear interest at the legal rate.

If the undersigned is a Medicare patient, he/she knows that Medicare may deny payment. If Medicare denies payment, he/she agrees to be personally and fully responsible for payment.

### 4. ASSIGNMENT OF INSURANCE BENEFITS

The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to Santa Barbara Extremity MRI of any insurance benefits otherwise payable to or on behalf of the undersigned for the services rendered. It is understood by the undersigned that he/she is financially responsible for charges not covered by his/her insurance company under this agreement.

### 5. ARBITRATION

It is understood that any dispute as to medical malpractice, that is to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompletely rendered, will be determined by submission to arbitration as provided by California law, and not by lawsuit or resort to court processes except as California law provides for judicial review of arbitration proceedings. Both parties to this contract by entering into it are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Such arbitration shall be in accordance with the current Medical Arbitration Rules of the California Hospital Association - California Medical Association (copies available upon request). This arbitration agreement shall apply to any legal claim or civil action in connection with this imaging center against Santa Barbara Extremity MRI or its employees and any doctor of medicine who has agreed, at the time of your admission as evidence by written agreement in the physician's medical staff file to be bound by this provision, unless patient or undersigned initials below or unless rescinded by written notice within 30 days of signature. An agreement to arbitrate shall not be a precondition to the rendering of services under this agreement.

The undersigned certifies that he/she has read the foregoing, received a copy thereof if requested, and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's agent to execute the above and accept its terms.

#### NOTICE:

**BY SIGNING THIS CONTRACT (BACK PAGE) YOU ARE AGREEING TO HAVE  
ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION  
AND YOU ARE GIVING UP YOUR RIGHT TO A JURY/COURT TRIAL.**

## 6. LOST OR STOLEN PERSONAL ITEMS

Santa Barbara Extremity MRI is not responsible for any misplaced, broken, or stolen personal items on the premises. All personal effects are the patient's responsibility.

### Insurance Check Acknowledgement

Please read the following information regarding your financial responsibility for your exam at Santa Barbara Extremity MRI ("SBEMRI") and acknowledge your understanding of this information by signing below.

- SBEMRI will submit a claim to your insurance provider for the use of our facility during your procedure.
- Your insurance provider may send a check directly to you. Please understand that any check sent to you for services rendered by SBEMRI should be endorsed by you to SBEMRI and returned to our office immediately. If the check is not returned to the facility, it will be included in your balance due. Please note the check from your insurance provider is separate from your patient portion.
- Please keep in mind that SBEMRI's fees are for your use of our Facility. You will receive a separate bill from the interpreting Radiologist ("CCRA").

### Privacy Notice Acknowledgement

I have been offered and reviewed a copy of the Privacy Notice from Santa Barbara Extremity MRI.

### Identity Theft Regulation

In compliance with recent legislation regarding identity theft, our center is required to verify each patient's identity prior to service. Please provide photo identification (Driver's License, ID card, passport, etc) with you to the front desk. If you are a minor and do not have current photo identification, we can take a guardian or parent's identification in your place. If you do not have a current photo identification card for any other reason, you will need to have someone with you that can verify and attest to your identity and we will need a copy of their photo identification.

**I have read the Condition of Admission, Insurance Check Acknowledgement and the Privacy Notice Acknowledgement information provided.**

**I have received information in a language I understand and been given an opportunity to ask questions about:**

- **Advance Directives**
- **My Rights as a Patient**

**I have read this packet of information prior to the date of surgery.**

Patient Name (print) \_\_\_\_\_

Patient or Representative (signature): \_\_\_\_\_ Relationship: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_ am/pm