UNIVERSITY RADIOLOGY

Patient's Name: (Please Print)_____

I understand that I am responsible for my bill at **UNIVERSITY RADIOLOGY,** including any portion of the bill that is **not covered by my INSURANCE**. This may not apply if your procedure is covered by TennCare on the date of service. If I expect any portion of my bill to be reimbursed or paid by insurance or a prepaid health plan, it is my responsibility to notify my physician of all insurance information and what my insurance carrier requires. I authorize release of information on my care to my insurance companies, and I authorize all companies to make payment directly to **UNIVERSITY RADIOLOGY**. I authorize my physician (or his/her office) to act as my agent to help me obtain pre-certification as well as acting as my agent to help obtain payment from my insurance companies. I authorize my insurance companies to give my physician or my physician's assigns any information they require to fulfill this function. I understand that I am responsible for clerical fees for additional insurance forms, disability forms, or statements in excess of what is normally provided.

ATTENTION SELF-PAY PATIENTS

AUR requires mandatory pre-payment for clinic visit up to $200 and $500 pre-payment for procedures.

By signing below I am agreeing to the above and my signature confirms that this form may also be utilized to request additional medical information from any hospital or practitioner who has cared for me.

_____	_____	_____
Patient or Responsible Party	Social Security #	Medicare #

Date:_____ Witness:_____