Reports & Film Acknowledgement:

One set of MRI films and the MRI report will be supplied to the physician who ordered your MRI at no charge. Should you be referred elsewhere, you must obtain the films and MRI report from your original physician to take to the doctor you have been referred to for continuing care, if required.

- If you need a copy of your MRI **report** sent to another physician and your referring physician is unable to forward it, we must obtain your written consent to forward the information. You may initiate this by contacting us toll free at 1-866-398-7364 and we will fax, e-mail or mail you the release form. Upon receipt of the completed release form we will forward your report to the physician specified.

- If you are not able to obtain your original films from the physician who ordered the MRI, films can be reprinted and shipped to your home or office for a fee of **$75.00**. Payment must be made prior to shipment and can be made in the form of credit card, debit card or check. Contact us toll free at 1-866-398-7364 to make arrangements. Please allow 7 days from the date of payment until the date of delivery. Expedited shipping may incur an additional cost.

CareSelect Program Acknowledgement:

EIP is pleased to offer our ***CareSelect Program***. This program allows eligible patients with out of network benefits to receive their extremity MRI scans at an EIP facility, even if EIP is not their in network provider. All out of network fees are waived under the program. Patients will only be responsible for any **in network** deductible, co-pay, or coinsurance.

Patients covered by any of the following insurance carriers are not eligible for the ***CareSelect Program***:

- HMO plans with no out of network benefits
- Government programs
- Health plans for Federal employees
- Worker's Compensation
- Motor vehicle accident claims

I HAVE READ AND UNDERSTAND THE NATURE OF THIS ACKNOWLEDGEMENT.
I WILL BE RESPONSIBLE FOR ANY IN NETWORK INSURANCE BALANCES.

Patient Signature _____ **Date** _____

Patient Name (printed) _____

Parent/Guardian Signature _____ **Date** _____

AUTHORIZATION TO DISCUSS PRIVATE HEALTH INFORMATION

I authorize EIP to discuss the details of my procedure as it relates to treatment and payment with the authorized party mentioned below. I understand that I may revoke this authorization at any time by submitting a written request to EIP.

Authorized Party Name (printed) _____

Relationship to Patient _____

Patient Signature or Parent/Guardian Signature _____ **Date** _____

I authorize EIP to leave a detailed message regarding my procedure as it relates to treatment and payment on the voice recording system associated with the following:

- ❒ Home Phone
- ❒ Work Phone
- ❒ Cell Phone