RAH
RADIOLOGY ASSOCIATES of HARTFORD, P.C.

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Consent and Acknowledgment

Thank you for choosing Radiology Associates of Hartford, P.C. ("RAH") for your health care. Please read this form in its entirety and then sign where indicated below.

Consent to Treatment: I hereby grant RAH and its employees and agents permission to perform diagnostic and/or interventional radiological procedures on me, as may be requested by my treating physician. I affirm that the risks and benefits of these procedures have been explained to me by RAH and/or my treating physician, and I have freely decided to receive the care.

Assignment of Benefits: I hereby agree to pay all charges for the services performed by RAH. If I have insurance, I hereby assign any benefits to which I may be entitled to RAH and grant RAH permission to bill my insurer and be paid directly. I also agree to pay all charges for laboratory services rendered by area laboratories as a required element of my imaging exam. If I am eligible for Medicare, Medicaid, or Tricare benefits, I request the charges be processed according to their requirements. I understand that I am responsible for any charges not covered by my insurance, including, without limitation, any co-payments, co-insurance amounts, or deductibles. Patients with a credit balance with Radiology Associates of Hartford, P.C., agree to apply credit balances to any open charges.

Protected Health Information: I hereby give my consent for RAH to both use and disclose my protected health information ("PHI") for the purpose of carrying out treatment, obtaining payment, or conducting certain healthcare operations. PHI used or disclosed by RAH may include HIV/AIDS related information, psychiatric and other mental health information, and drug and alcohol treatment information, subject to applicable law. **I understand that this consent is effective for as long as RAH maintains my PHI.**

Acknowledgement of Receipt of Notice of Privacy Practices: I hereby acknowledge receipt of RAH's Notice of Privacy Practices, which I understand describes more particularly how RAH will protect, use, and disclose my PHI, as well as describes my privacy rights as a patient of RAH.

Communications Via Cellular Phone and/or Email: I hereby acknowledge and agree that by providing a cellular telephone number and/or email address as a primary contact method that I am authorizing RAH to contact me via cellular phone, text message, or email for any reason, including, without limitation, feedback surveys, automated notifications, and appointment reminders. I understand that these channels of communication may not be secure, but I agree to accept the risk of potential interception by third parties because I value the convenience of these methods of communication. I understand that my right to request confidential communications is described in RAH's Notice of Privacy Practices.

Personal Valuables: I have been informed that this office maintains a safe for safekeeping of money and other valuables. I understand and agree that neither RAH or its employees or agents will be responsible for the loss or damage to personal possessions that I do not have placed in the safe.

By signing below I understand and acknowledge the following:
- I have read and understand this consent and acknowledgement;
- I am authorized to execute this form, and I agree to its terms;
- I have received a copy of RAH's Notice of Privacy Practices.

Patient or Authorized Representative	Relationship	Date	Time