Patient Name: ___________________________________**Office**: __________________

EXAM:____

I/we hereby guarantee payment of all charges made for or on the account of the patient and hereby assign to **SonoCare, LLC Outpatient Imaging Center and their interpreting physician** any and all right the patient and I have, or to which we may become entitled, to or with regard to any and all medical benefits, health benefits, PIP benefits, benefits due to sickness or injury, or any other health, accident, or welfare benefit of any type or form relating to the liability of or payments made by third party or by any person, employer, or insurance company on the party's behalf to or for the patient unless the account is paid in full at time of service. If eligible for Medicare, I request Medicare services and benefits. I understand I am responsible for any charges not covered by the insurance or other form of health or welfare benefit, Medicare, Medicaid, or other benefits.

In the event that a claim for payment submitted by above provider(s) to my insurance carrier is denied, I hereby authorize provider(s) to seek an administrative review of the disputed claim in accordance with the applicable provisions(s) of my plan or policy.

I authorize SonoCare, LLC Outpatient Imaging Center and their interpreting physicians to disclose necessary medical information about me to the Centers for Medicare and Medicaid and its agents or my Private Insurance Carrier information needed to determine these benefits or the benefits payable for related services

I have received a copy of SonoCare LLC's Outpatient Imaging Center Notice of Privacy Practices and know that I may review and/or receive an additional copy at any time from SonoCare, LLC 125 C Wamsutta Mill Road Morganton, NC 28655. Telephone: 1-828-430-3511

____ _____________

Signed: (Patient or authorized person) **Date**

Rev 10/13