Guam Radiology Consultants

Guam Medical Plaza, Suite 210 633, Governor Carlos Camacho Road, Tamuning, Guam 96913
Tel: (671) 649-1001 Fax: (671) 649-1002

ASSIGNMENT OF INSURANCE BENEFITS:

For the rendering of services requested, I hereby allocate all relevant benefits arising from the applicable insurance policy, which insures myself or all other parties liable under myself, directly to Guam Radiology Consultants.

AGREEMENT FOR PAYMENT:

This document constitutes an agreement for services to be rendered by Guam Radiology Consultants to the patient noted below. Guam Radiology Consultants will submit insurance claims to the medical insurance provider noted below, if any. You, the undersigned (whether signing as the patient, parent, legal guardian, legal spouse or representative of the patient) will be financially responsible for:

1. All medical services if you do not have health insurance.
2. All medical services if the medical insurance coverage indicated below is not effective at the time of these services.
3. Any services provided to you that is not covered by the medical insurance indicated below,
4. Any co-payment or deductible that is required as a member participating in the insurance program indicated below.

You agree to pay amounts billed to you within 30 days of the bill. If you fail to make payment when due, you will also be charged an interest rate of 1% per month (12% annually). By signing below, you agree to be bound by these terms.

RELEASE OF INFORMATION:

I hereby authorize Guam Radiology Consultants the permission to release any medical records for the completion of my medical claims.

I authorize Guam Radiology Consultants to release or request copies of medical records for the course of my examination or treatment. A photocopy or faxed copy will serves as an original. I understand that the information on this form may be released to other health care providers or entities as needed during the course of my medical examination or treatment. I also direct any facilities receiving a copy of this form to release original copies of all exams, reports of results and clinic notes, pathology reports and/or any other information relating to my care as requested by Guam Radiology Consultants.

This form, unless directed by me to be invalidated, shall remain effective for six (6) months from the date of my signature.

PRINT PATIENT'S NAME: **DATE OF BIRTH:**

_____ _____

LAST NAME **FIRST NAME** **MI** **MONTH / DATE / YEAR**

_____ _____

PRINT NAME OF GUARDIAN OR LEGAL REPRESENTATIVE ***RELATIONSHIP TO PATIENT***

_____ _____

SIGNATURE ***DATE***

_____ _____

PRIMARY INSURANCE AND POLICY NUMBER **SECONDARY INURANCE AND POLICY NUMBER**

Print Form