

ImageCare Schodack

Patient Name _____ *Date of Birth* _____

I hereby authorize the release of any medical information necessary to process this bill to my insurance company. I authorize payment of medical benefits to Community Care Physicians, P.C.
I acknowledge that I am financially responsible for payment for those services not covered by my insurance company.*

Signature: _____ Date: _____

(PATIENT OR RESPONSIBLE PARTY)

(RELATIONSHIP IF RESPONSIBLE PARTY)

*Members of New York State certified managed care organizations are excluded in most instances except where the member has been advised that the service(s) may not be covered by that respective contract prior to the service(s) being rendered.

*ImageCare is responsible to discuss the medical reason for the services being performed so that an informed consent can be obtained.