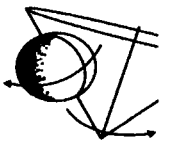
Carlsbad Imaging Center
6010 Hidden Valley Rd., Ste. 125
Carlsbad, CA 92011
P (760) 730-3536 F (760) 720-4833
www.carlsbadimaging.com



Imperial Radiology
2407 Marshall Ave., Ste. A
Imperial, CA 92251
P (760) 545-0340 F (760) 545-0341
www.imperialcountyradiology.com

Agreement for Services (For Patients Paying by Cash)

1. **Patient or patient guardian must acknowledge ONE of these statements by signing their initials:**

_____I declare that I do have medical insurance for today's exam BUT I am choosing to pay out of pocket for the exam and bypass my medical insurance.

_____I declare that I do NOT have any medical insurance for today's exam.

_____I declare that my medical insurance denied authorization for my exam and I am choosing to pay out of pocket for the exam.

2. **Patient or patient guardian must acknowledge every statement by signing their initials:**

_____ I understand it is AM & BB Imaging Center Inc., DBA: Carlsbad Imaging Center (CIC) and Imperial Radiology (IR) normal procedure to bill a patient's insurance provider when the patient has been referred by a doctor and has medical coverage at the time of service. I am choosing to pay for services directly and understand that CIC and IR will not bill my medical insurer at any time whether current or retroactively for the service rendered today.

_____ Furthermore, I understand that CIC and IR will not bill Medi-Cal, Medi-Cal managed care plans, Medicare, and or any private insurance (whatever is applicable) for my rendered services whether current or retroactively. I am choosing to pay for services directly and understand that CIC and IR will not bill my medical insurer.

_____I declare that I (the patient) do not have a pending application for Medi-Cal.

_____I request to pay in full for all charges incurred for services provided by CIC and or IR today and understand that no refund will be given.

_____ I understand that CIC and IR will not, on my behalf, bill any insurance whether current or retro-active and under any circumstances for services rendered today.

_____ I understand that CIC and IR will provide me with a simple receipt for the exams rendered and paid for today.

_____ I understand that CIC and IR will not provide me an itemized bill for today's services at any time.

Patient Name: _____
Guardian Name: _____ (if applicable)
Patient DOB: _____
Exam(s): _____
Exam Date: _____
Patients Signature: _____
Date: _____