INSIGHT
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Flint, MI 48507-2669
Tel: (810) 732-8336
Fax: (810) 963-1674
clinic@iinn.com

WAIVER OF LIABILITY

CONSENT: I request and authorize health care as my physician and his/her designees may deem advisable. This may include routine diagnostic, radiology and laboratory procedures and medication administration.

RELEASE: I authorize the release of medical and other information to my insurance company to review of my coverage and/or for the processing of claims for services rendered to me/my child. I permit a copy of this authorization to be used in place of the original.

PAYMENT: I assign and authorize payment for any and all services rendered, directly to:

Insight Radiologist, PC / Insight Imaging

For my insurance company or third party payee including, but not limited to, Medicare, Medicaid, commercial health insurance, automobile no fault insurance, and workers disability compensation insurance. I understand I am responsible for any charges incurred that are not covered by my insurance company. I understand that I am responsible for my insurance copay at the time of services rendered.

I have read the above noted information and understand it:

_____
(Print Name)

_____ _____
(Signature of Patient/Guardian) (Date)