

## Agreement for Third Party Medical Imaging Examinations

Trillium Health Partners requires completion of this Agreement prior to booking or performing Third-Party imaging examinations. This form must accompany all Third-Party referrals.

### **Part A**

I, (print name) \_\_\_\_\_ being an authorized representative of  
(name of Insurance Co., Employer, Law Office) \_\_\_\_\_,  
agree to assume all responsibility for the funding of this test on a third party basis including compliance with the  
cancellation policy. I also confirm that the patient is not paying for his/her test privately, is not related to the third party  
funding the test and that the patient is not directly reimbursing the third party.

I recognize that a copy of this document and a copy of the test results will be placed on the hospital patient record and  
all issues pertaining to confidentiality and release of records will comply with Hospital policy and the Public Hospitals Act  
and other related legislation and standards.

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Phone and Fax: \_\_\_\_\_

Date: \_\_\_\_\_ The test is required for: ( ) Benefits ( ) Rehab/ Assessment ( ) Legal Reasons

### **Part B**

Name of patient: \_\_\_\_\_ Claim Number: (required\*) \_\_\_\_\_

Insurer/Employer/Law Office Requesting Test \_\_\_\_\_ or  Same as part A (check)

Contact Name: \_\_\_\_\_ or  Same as part A (check)

Contact's Phone # \_\_\_\_\_

Name and address of institution to be billed for the test:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Copies of the report to be sent to: 1) \_\_\_\_\_ 2) \_\_\_\_\_**

### **To be completed by the patient after review by staff at the Department of Diagnostic Imaging**

Patient: I have read and understand the information above and verify that it is correct. I authorize the Hospital to release  
the information specified above to the individuals named above.

Date: \_\_\_\_\_ Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

### **Cancellation Policy**

If patient does not show for their appointment or the test is cancelled with less than 24 hours notice, a fee of \$437.50 will  
be charged to the party responsible for funding the test.