London, Cambridge, Newmarket, Mississauga, Scarborough, Ajax

Also: BC, AB, QC, NB, NS

Agreement for Third Party Medical Imaging Examinations

MRIappointments requires completion of this Agreement prior to booking or performing Third-Party imaging examinations. This form must accompany all Third-Party referrals. **Parts A and B must be fully completed.**

Part A

I, (print name) _____ being an authorized representative of (name of Employer, Athletic/Sports Entity, Law Office or Licensed Insurer Insuring the Patient) _____, 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 may be placed on the hospital's / clinic's patient record and all issues pertaining to confidentiality and release of records will comply with hospital /clinic policy respecting relevant legislation.

Print Name: _____ Title: _____ Date: _____

Signature: _____ Phone and Fax: _____ _____

The test is required for: (__)Benefits (__) Rehab/ Assessment (__)Legal Reasons

(__) admission to/continued attendance in a recreational/athletic club or program

Part B

Name of patient:_____ Is the patient the same as the policy holder? ☐ Yes ☐ No

Claim Number: _____ Date of Accident (mm/dd/yyyy)_____

Licensed Insurer/Employer/Law Office Requesting Test:_____or ☐ Same as part A (check)

Contact Name:_____Phone# (_____)_____ or ☐ Same as part A (check)

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

_____

_____

_____Branch (if applicable:)_____

Copies of the report to be sent to: 1)_____2)_____

Part C: To be completed by the patient after review by the staff at the hospital/clinic.

Patient: I have read and understand the information above and verify that it is correct. I authorize hospital/clinic to release the information specified above to the individuals or entities 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 equivalent of 50% of the exam cost will be charged to the party responsible for funding the test.

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