Unity Health Toronto

(this space for hospital use only)

Agreement for Third Party Medical Imaging Examinations

The Unity Health Toronto 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 (insert 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 and payment 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 Unity Health Toronto policy and the Public Hospitals Act and other related legislation and standards.

Payment is due to Unity Health Toronto upon receipt of the patient invoice.

Print Name: _____ Title: _____

Signature: _____ Phone _____ Fax: _____

Date: _____ This test is required for: ☐ Benefits ☐ Rehab/Assessment ☐ Legal Reasons

---

Part B

Name of Patient: _____ Claim/Reference # (required): _____

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

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

Contact's Phone #_____ Contact's E-mail: _____

Part C 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 the staff at the Imaging Centre.

Patient: I have read and understand the information above and verify that it is correct. I authorize Unity Health Toronto 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 equal to 50% of the cost of the exam will be charged to the party responsible for funding the test (ex. MRI - $447.50).