

Conditions of Service and Assignment of Benefits

Professional Services Agreement

I, the undersigned patient, or personal representative acting on the patient's behalf, hereby engage the services of the applicable medical providers for the provision of services and treatment of my medical condition.

Consent for Medical and Surgical Treatment

The patient hereby consents the procedures, which may be performed on an outpatient basis, including emergency treatment or service, which may include, but are not limited to, laboratory procedures, x-ray examinations, medical and surgical treatments or procedures, anesthesia, or special services rendered for the patient under the general and special instructions of the patient's physician or surgeon.

Assignment of Insurance Benefits

I hereby appoint, assign and convey directly to River Oaks MRI & Diagnostic referred to as the Provider, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the entities listed above, respectively, regardless of their managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby agree to reimburse the Providers for any and all costs of collection incurred to recover payment due from me for all medical services rendered to me by same, including reasonable legal fees. Furthermore, I hereby give permission to cross apply funds to any funds to any rendering provider.

Authorization for Release of Information

I hereby authorize the Providers to furnish requested patient information including, but not limited to, information relating to communicable diseases such as HIV and hepatitis, to the referring physician and to any insurance company or third party payer for the purpose of obtaining payment and process my claims for the services rendered. Further, I authorize the Providers to release information from my medical record to any other health care facility to which I may be transferred. Additionally, I authorize any plan administrator fiduciary, insurer, and/or attorney to release to the Providers any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request by the Providers or their attorneys in order to facilitate their claim for direct payment of such medical benefits.

Administrative Claim Assignment

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey the Providers and any legal or administrative claim or action arising under any group health plan, employee benefits plan or health insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the Providers. This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims. I intend by this assignment to convey to the Providers all of my rights to claim(or alternatively, place in lien on) the medical benefits related to the services, treatments, therapies, and/or medications provided including right to any settlement, insurance or applicable legal or administrative remedies (including damage arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above- named providers) is given the right by me to (1)obtain information regarding the claim to the same extent as me; (2) submit evidence; (3)make statements about facts or law; (4)make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or close in action or right against any liable party, insurance company, employee benefit plan, health care benefit

plan, or plan administrator. The above names Providers as my assignees and my designated authorized representatives may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at Provider's expense. This assignment is irrevocable and valid for all administrative and judicial review under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. To my knowledge, there is no prohibition to any assignment in my plan, if there is any prohibition, I agree to sign any document to allow the provider to be paid directly for services rendered to me.

Medicare Assignment (If covered by Medicare Insurance Coverage)

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I request that payment of authorized benefits be on my behalf. I authorize the release of any information needed to act on this request. I assign all reimbursements to which I may be entitled for direct payment to the covered by other insurance.

Irrevocable Assignment of Interest (If you have a personal injury claim against any third party)

I hereby give, grant and convey a irrevocable, undivided ownership right and lien on any such claim or cause of action an irrevocable, undivided interest in my claim and any settlement or payment to me for such injury up to the full amount billed by the Providers for such services, irrespective of partial payments received by any non-contracted third party insurance payers. I agree to notify Provider immediately of any changed in attorneys handling the subject claim.

Worker's Compensation

If the medical condition for which I seek treatment was caused by a work- related injury, I realize that I must, under Texas law and before any services are rendered, inform the Providers of the work- related nature of my condition, the identity of my employer and any other information needed to allow the Providers to file a claim for the cost of its services from my employer or worker's compensation carrier. Providers are required to submit a bill to the carrier within a certain time frame once a provider knows the injury is work related.

Personal Valuables

It is understood that River Oaks MRI & Diagnostic shall not be liable for the loss or damage to any money, jewelry, documents, furs (coats or garments) or other articles of unusual value and small size, and shall not be liable for loss or damages to any other personal property.

The undersigned certifies that he/she has read and understands the foregoing, received a copy thereof, and is the patient, patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

Patient/Guardian Signature: _____ **Date:** _____

Signature of Witness: _____ Date: _____

(River Oaks MRI & Diagnostic personnel)

A photocopy of this assignment is to be considered valid, the same as if it was original.