



2929 5th Street, Suite 100 | Rapid City, SD 57701 | (605) 342-2852 | (605) 342-3930 fax | (800) 456-1361 | www.dakota-radiology.com

**AUTHORIZATION TO FILE CLAIM**

I hereby authorize Dakota Radiology and/or Dakota PET/CT/& MRI, Rapid City, SD to file a claim for services to my insurance plan, Medicare, and/or any other government agency for reimbursement. I request that Dakota Radiology and/or Dakota PET/CT & MRI furnish any and all information they may require from my record in order to process such a claim.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Policyholder

**ASSIGNMENT OF BENEFITS**

I hereby authorize payment of benefits from my insurance plan, Medicare, and/or any other government or private plan to be paid directly to Dakota Radiology and/or Dakota PET/CT & MRI, which will be credited to my account. I also understand that I am financially responsible for any amounts not covered by my insurance company including co-payments, co-insurance amounts, deductibles and any amount over the usual reasonable and customary guidelines.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Patient

**NOTICE OF PRIVACY PRACTICE RECEIPT**

Your signature indicates you have received a copy of and/or had the opportunity to request a copy of the Dakota Radiology and/or Dakota PET/CT & MRI "Notice of Privacy Practice".

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Patient

**CONSENT FOR DIAGNOSTIC IMAGING OF MINOR PATIENT**

Your signature indicates that you are granting permission for your minor child (or child in your legal guardianship) to receive diagnostic imaging at Dakota Radiology and/or Dakota PET/CT & MRI for services this date. Your signature indicates that you are the legal parent or guardian of this minor child and are legally able to authorize treatment for this child. You may be asked to present proof of guardianship by the staff of Dakota Radiology and/or Dakota PET/CT & MRI in order to proceed with today's exam for the minor child. This consent will be valid for **this date only**. Each time this minor child presents to this facility, a new consent form will need to be signed.

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

Relationship to Minor Child: \_\_\_\_\_

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For office use only: Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient Imagine Account #: \_\_\_\_\_

Verification of Legal Guardianship: \_\_\_\_\_ by \_\_\_\_\_

Type of Identification Provided: \_\_\_\_\_