



OPEN MRI *of* SANPC

1040 EAGLES LANDING PARKWAY
SUITE 102
STOCKBRIDGE, GA 30281

PATIENT INSURANCE WAIVER

I hereby, authorize the Physicians and Staff of Open MRI of SANPC, PC to provide medical care for _____.

I consent to the release by Open MRI of SANPC, PC of any medical information necessary to process any and all-insurance claims.

I understand in the event my insurance carrier denies payment in full of any services rendered. I am responsible for payment. I and responsible for all co-payments and or deductibles, and non-covered services and supplies obtained during the course of my care.

By signing this form, you agree to pay for services not paid by your insurance company in full.

Patient Name: _____

Date: _____

Signature(patient or guarantor): _____