Consent for Diagnostic Imaging and Payment for Uninsured Services

Thank you for choosing Wentworth-Halton X-Ray and Ultrasound. Please review the consent form below so we may provide the optimal diagnostic care for you and to bill appropriately.

CONSENT FOR TREATMENT
By signing this form, I consent to and authorize the provider(s) at Wentworth-Halton X-Ray and Ultrasound Inc. (WH X-ray) to provide me or my dependent with diagnostic imaging services.

NOTIFICATION OF PRIVACY
WH X-ray complies with the Personal Health Information Protection Act, 2004 (PHIPA).

CONSENT TO BILL AND RECEIVE PAYMENT
I understand that I am responsible for any payment of uninsured fees that are not covered by Provincial Health Insurance and that I will be billed directly and responsible for payment for those services for myself or my dependent.

I understand that payment for the uninsured services must be received **prior** to exiting the diagnostic clinic.

I agree that by refusing to sign this consent, WH X-ray may not be able to provide services to me or my dependent.

My signature below indicates that I understand and accept the content of this form.

Signature _____ Date _____

Patient Name (print name)_____

Patient Representative (print name)_____
(if applicable or patient is under the age of 18)

Relationship to Patient: _____