DOCTOR'S LIEN & ASSIGNMENT OF MEDICAL BENEFITS

I understand that **my doctor is submitting my x-rays to Midwest Radiology Consultants for radiological evaluation.** I also understand that the fee for such services will be submitted to my insurance company, workers' compensation carrier, or my attorney

I authorize my insurance company to **pay directly to Midwest Radiology Consultants for services rendered.**

In the event my insurance company, attorney, or workman's compensation carrier does not reimburse for the fee in full, or if I do not have insurance coverage, **I agree that I am directly responsible for the charges or any unpaid portion.** Returned checks for insufficient funds will be assessed a $20.00 service charge. ***Accounts delinquent by 90 days from the time of my 1st billing statement may be placed with a legal collection agency. I am fully responsible for all collection costs unless prior payment arrangements have been made with Midwest Radiology Consultants.***

I understand that Dr. Doran L. Nicholson is not a participating provider in my insurance plan and that his services may not be covered by my insurance. ***I also understand that this service is not covered by Medicare.***

In the event that my insurance company sends payment directly to me, I agree to promptly remit such payments to Midwest Radiology Consultants.

Patient Signature:

_____

(Patient, Parent or Guardian)

Date: _____

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