Patient Self-Referral Waiver for Imaging Services

I, _____ (Patient Name), hereby acknowledge that I am self-referring for non-acute screening imaging services at The Imaging Center,PC located at:1625 Leonard St NE, Grand Rapids, MI 49505, and/or 710 Kenmoor Ave SE, Grand Rapids, MI 49546.

I understand and agree to the following:

1. Self-Referral Acknowledgment: I am requesting these imaging services on my own behalf, without a referral from a physician or healthcare provider.
2. Responsibility for Follow-Up Care: The Imaging Center,PC is not responsible for any follow-up medical care, explanation of imaging reads, medical advice, or diagnosis related to the services provided. I am solely responsible for providing the imaging reports to my own physician or healthcare provider.
3. No Forwarding of Images or Reads: The Imaging Center,PC will not forward any images or imaging reads to any third party, including my physician, unless I specifically request and authorize such forwarding in writing.
4. Self-Pay Requirement: I acknowledge that I must self-pay for all imaging services received at The Imaging Center,PC. These services will not be submitted to my in-surance for reimbursement, and I am responsible for all costs associated with the imaging services.
5. Release of Liability: By signing this waiver, I release and discharge The Imaging Center,PC, its employees, agents, and affiliates from any and all liability, claims, demands, or causes of action arising out of or in connection with the imaging services provided.

I have read and understand this waiver and release, and I sign it voluntarily.

Patient Signature: _____ Date: _____

Print Name: _____

Address: _____

Phone Number: _____

Email: