Agreement for Third Party Medical Imaging Examinations

Mackenzie Health requires completion of this Agreement prior to booking or performing Third-Party imaging examinations. This form must accompany all Third-Party referrals. **Parts A and B must be fully completed.**

Part A

I, (print name) _____ being an authorized representative of (name of Employer, Athletic/Sports Entity, Law Office or Licensed Insurer Insuring the Patient) _____, agree to assume all responsibility for the funding of this test on a third party basis including compliance with the cancellation policy. I also confirm that the patient is not paying for his/her test privately, is not related to the third party funding the test and that the patient is not directly reimbursing the third party.

I recognize that a copy of this document and a copy of the test results will be placed on the hospital patient record and all issues pertaining to confidentiality and release of records will comply with hospital policy and the Public Hospitals Act and other related legislation and standards.

Print Name: _____ Title: _____ Date: _____

Signature: _____ Phone and Fax: _____ _____

The test is required for: (__)Benefits (__) Rehab/ Assessment (__)Legal Reasons

(__) admission to/continued attendance in a recreational/athletic club or program

Part B

Name of patient:_____ Is the patient the same as the policy holder? ☐ Yes ☐ No

Claim Number: _____ Date of Accident (mm/dd/yyyy)_____

Licensed Insurer/Employer/Law Office Requesting Test:_____or ☐ Same as part A (check)

Contact Name:_____Phone# (_____)_____ or ☐ Same as part A (check)

Name and address of institution to be billed for the test:

_____

_____

_____Branch (if applicable:)_____

Copies of the report to be sent to: 1)_____2)_____

Part C: To be completed by the patient after review by the staff at the Imaging Centre.

Patient: I have read and understand the information above and verify that it is correct. I authorize Mackenzie Health to release the information specified above to the individuals named above.

Date:_____ Printed Name:_____

Signature: _____

Cancellation Policy

If patient does not show for their appointment or the test is cancelled with less than 24 hours notice, a fee of $425.00 will be charged to the party responsible for funding the test.

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