Trillium Health Partners
Better Together

Credit Valley Hospital
Trillium Health Partners
Department of Diagnostic Imaging
Tel: 905 813 4179 Fax: 905 813 4172

Agreement for Third Party Medical Imaging Examinations

The Credit Valley Hospital (Trillium Health Partners) requires completion of this Agreement prior to booking or performing Third-Party imaging examinations. This form must accompany all Third-Party referrals.

Part A

I, (print name) ____ being an authorized representative of (*name of Insurance Co., Employer, Law Office*) ____, 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: ___________________________________

Signature: _________________________________ Phone and Fax: ____________________________

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

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Part B

Name of patient:__________________________________ Claim Number: (required*)___________________

Insurer/Employer/Law Office Requesting Test________________________________or ☐ Same as part A (check)

Contact Name:____ or ☐ Same as part A (check)

Contact's Phone #____

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

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Copies of the report to be sent to: 1)_______________________________2)____________________________

To be completed by the patient after review by staff at the Department of Diagnostic Imaging

Patient: I have read and understand the information above and verify that it is correct. I authorize the Hospital 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 $437.50 will be charged to the party responsible for funding the test.