



Authorization to Bill Insurance

I, _____, give my permission to Northwest MRI to bill my insurance. I understand that my portion paid today _____ may change once the insurance has received, and reviewed my claim, and that I am financially responsible for anything not covered by my insurance. I also give my permission to Northwest MRI to release any protected health information to my insurance necessary to process my claim.

Patient signature: _____ Date: _____

Patient Name: _____ Account # _____

Copy of Insurance Card