X-RAY ASSIGNMENT AGREEMENT AND CONSENT

I understand that my doctor is submitting my x-rays to Spinal Imaging, Inc. for primary radiological interpretation and report by a specialist. I also understand that the fee for such services will be submitted to my insurance company, healthcare carrier, attorney or worker's compensation carrier for payment. If I am paid directly by an insurance carrier or through a legal settlement, I will be responsible for the amount paid. If Spinal Imaging, Inc. does not receive a lien, or if Spinal Imaging, Inc. does not receive a reply to a case status information request from my attorney, I will be billed for the amount of service. Once Spinal Imaging, Inc. receives a reply from the attorney, I will stop being billed.

I also give my consent to Spinal Imaging, Inc's use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes.

I understand I have the right to request a restriction on the use and the disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I have the right to revoke this consent, in writing, at any time, except to the extent that the Practice has acted in reliance on this consent. I acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Spinal Imaging, Inc, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

My signature authorizes the release of medical information and also authorizes the assignment of benefits to:

Spinal Imaging, Inc.

5 Norfolk Avenue

P. O. box 1200

South Easton, MA 02375

In the event my insurance company or attorney sends payment of services to me,, I agree to promptly remit such payment to Spinal Imaging, Inc.

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Printed Name

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Patient Signature Date

Ver 11/05

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