



Patient Consent

Service Provider: Site Name

I have read and understood the brochure "Important information for patients". I acknowledge that:

1. I may incur an out-of-pocket expense for radiology and/or nuclear medicine services provided to me by the service provider specified above;
2. I will be responsible for and will pay, any invoice received from the service provider for radiology and/or nuclear medicine services provided to me in a timely manner; and
3. The service provider may use personal information collected about me in the manner specified in its Privacy Policy.

Patient Name

Patient Signature

Date