RADIOLOGY ASSOCIATES OF RIDGEWOOD, P.A.

PATIENT BILL OF RIGHTS:

Radiology Associates of Ridgewood, P.A. ("RAR") exists for the purpose of providing high quality care that meets or exceeds accepted standards of care. RAR believes that each patient is worthy of respect and understanding and has certain rights and responsibilities related to the care he/she receives.

As a patient of RAR, I have the right to:

- Be treated with dignity, courtesy and respect, including the right to independent personal decisions...
- Be fully informed upon request, prior to services being rendered, of all retail charges for services.
- Be communicated with in a way that is easily understandable.
- Refuse treatment and diagnostic tests (as permitted by law) and to be informed of the medical consequences of such refusal.
- Voice grievances about care which is or is not provided, recommend policy/service changes and make complaints without fear of reprisal or unreasonable interruption of care.
- Exercise civil and religious liberties, including the right to independent personal decisions.

I also understand that I have a responsibility to:

- Provide to the best of my knowledge accurate and complete information as it relates to the status of my health and care.
- Make it known whether or not I understand the care and diagnostic tests to be performed, and take an active role in my treatment by being informed and prepared.
- Verify with my insurance company whether RAR participates with my particular plan and program.
- Obtain precertification, preauthorization or other coverage verification from my health insurance company before services are rendered.

RELEASE OF PATIENT RECORDS AND INFORMATION

In order to allow RAR and its physicians, employees, agents and representatives to obtain reimbursement, I authorize and consent to the disclosure of information or parts of my Medical Record (even if it includes diagnoses and treatment of AIDS, HIV infection or HIV related illness and treatment of alcohol abuse and/or drug abuse). These disclosures may be made during the course of my treatment and after treatment. Disclosure may be made to any person or corporation who may be liable to RAR or its physicians for all or part of their charges (i.e. myself, my spouse, hospital or medical service companies, my employer, HMO's, insurance companies, workers' compensation carriers, welfare fund or government agencies). **DISCLOSURES TO THE AFORE MENTIONED PARTY(S) WILL ONLY BE MADE IF THE PARTY(S) IS RESPONSIBLE FOR PAYMENT.** Disclosures may include, but are not limited to, my identity, diagnosis, prognosis and/or treatment or procedures performed and costs, charges and expenses incurred.

I authorize and consent to RAR and its representatives to appeal, on my behalf, any authorization or other coverage determination made by my HMO, insurance company or designated review agency, which results in a denial, termination or other limitation of covered health care services.

I authorize RAR and its representatives to discuss with and/or provide access to my medical records and information to any person or organization as is necessary to facilitate the provision of medical care, treatment or payment of these services.

AGREEMENT TO PAY FOR SERVICES AND ASSIGNMENT OF REIMBURSEMENT BENEFITS

In consideration of the services rendered to me, I agree to be financially responsible for charges for all services received. I hereby assign insurance benefits directly to RAR which otherwise may be payable to me. I understand that my health insurance company or payer may require me or my doctor to obtain precertification or preauthorization for services performed by RAR. Although it is the policy of RAR, as a courtesy to its patients and referring physicians, to assist whenever possible in confirming and validating insurance coverage and preauthorization, I understand that it is my responsibility to secure such coverage and preauthorization. I further understand that failure to do so will result in these services being considered "non-covered", making me responsible for payment. I understand that delinquent accounts will be forwarded to a collection agency.

We value the privacy of our patients and are committed to operating in a manner that promotes patient confidentiality while providing high quality patient care. If we have fallen short of this goal, we want you to notify us. It is our intent to use this feedback to better protect your rights to patient confidentiality and to improve the quality of patient care. Complaints, recommendations or grievances should be reported in writing to:

Debra Garde
Practice Administrator
Radiology Associates of Ridgewood, P.A.
20 Franklin Turnpike
Waldwick, NJ 07463
201-445-8822 ext. 111
Fax: 201-857-1101
E-mail: Dgarde@ridgewoodradiology.com
www.ridgewoodradiology.com

- ❑ **I certify that I have read and fully understand the above information.**
- ❑ **I acknowledge that I was provided a copy of RAR's Notice of Privacy Practices.**
- ❑ **I certify that _____ is my primary insurance.**
  Insurance name

_____ _____
Patient signature (or legally authorized representative) Date

Revised 5/13/20