SOUTHWEST DIAGNOSTIC IMAGING, LLC

Main Phone: (480) 425-5000
www.eSMIL.com

Patient Name: ____

PID: ____

Date of Service: ____

CPT(s): ____

Exam(s): ____

Price: ____

Prior Authorization Waiver and Payment Agreement

I have requested to receive health care services provided by Southwest Diagnostic Imaging, LLC, dba Southwest Medical Imaging, prior to obtaining the required authorization by ____________________________________.

I understand my health insurance may deny the prior authorization request if services are deemed not medically necessary, investigational, or other reasons for non-coverage determined by my health plan.

I agree to be personally responsible for these services in the event my health insurance denies the charges for services not authorized.

My signature below indicates that I have received a copy of this document and I am fully aware if the exam performed today is denied I will be financially responsible for the any charges incurred.

Signature: ______________________________

Date: ______________________________