GLENDALE DIAGNOSTIC IMAGING NETWORK MEDICAL OFFICE, INC.

Name:					DO	B:		Sex: M / F
Last		First		MI				
Address:	Street				City		State	ZIP Code
SS/ID No:		Tel:				Alt. Tel: _		
File No:		Insurance:	M/Care	M/CaI PI	PO PI I	HMO Cash	N/C Oth	ner:
CONSENT FOR	DIAGNOSTI	C PROCED	OURE;					
2. I understand unsuccessfu	ny referring phys I the procedure(s I results, complic I to the physician	ician or other) as it was exp cations or inju	health car lained to r ry, from b	e provider, a me and under oth known o	s described rstand that r unforesee	l below it may involv en causes.	e risk of p	pain, bleeding,
1	,							X
								Patient Init
fully with the GDII may be set forth ar unnecessary and a insurance carrier to in the human const	nd by paying fees s such, or for an make payments	s and charges ny other reaso directly to GI	in full as lon are dea OIN for th	billed, especi nied by the e provided s	ially if serving insurance ervices. It	vices provide provider. The is also agreed	d are four e PATIEN l that beca	nd to be medical NT authorizes the use of difference
					X:	Pa	ntient Sign	ature
PROCEDURE(S	6)							
Date	Requested Pro	ocedure	Re	eferring Prov	ider	Patien	t Signature	e Tech. In
			<u> </u>			X:		
			<u> </u>			X:		
						X:		
						X:		
						X:		
			-			X:		