Trillium Health Partners
Department of Diagnostic Imaging
Credit Valley H: Fax: 905 813 4172
Mississauga H: Fax: 905 848 7295

Agreement for Third Party Medical Imaging Examinations

Trillium Health Partners requires completion of this Agreement prior to booking or performing Third-Party imaging examinations. This form must accompany all Third-Party referrals.

Part A

I, (print name) _____ being an authorized representative of (*name of Insurance Co., Employer, Law Office*) _____, agree to assume all responsibility for the funding of this test on a third party basis including compliance with the cancellation policy. I also confirm that the patient is not paying for his/her test privately, is not related to the third party funding the test and that the patient is not directly reimbursing the third party.

I recognize that a copy of this document and a copy of the test results will be placed on the hospital patient record and all issues pertaining to confidentiality and release of records will comply with Hospital policy and the Public Hospitals Act and other related legislation and standards.

Print Name: _____ Title: _____

Signature: _____ Phone and Fax: _____

Date: _____ The test is required for: (__)Benefits (__) Rehab/ Assessment (__)Legal Reasons

Part B

Name of patient:_____ Claim Number: (required*)_____

Insurer/Employer/Law Office Requesting Test_____or ☐ Same as part A (check)

Contact Name:_____ or ☐ Same as part A (check)

Contact's Phone #_____

Name and address of institution to be billed for the test:

_____

_____

_____

Copies of the report to be sent to: 1)_____2)_____

To be completed by the patient after review by staff at the Department of Diagnostic Imaging

Patient: I have read and understand the information above and verify that it is correct. I authorize the Hospital to release the information specified above to the individuals named above.

Date:_____ Printed Name:_____

Signature: _____

Cancellation Policy

If patient does not show for their appointment or the test is cancelled with less than 24 hours notice, a fee of $447.50 will be charged to the party responsible for funding the test.

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Mississauga H.:100 Queensway West, Mississauga ON L5B 1B8
Questions: 1 866 899 4674 – visit www.MRIappointments.com