BILLING AUTHORIZATION

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ the undersigned patient hereby agrees and directs Advanced Diagnostic Medical Imaging, Inc. to mail or otherwise send billing statements and invoices and related correspondence for Advanced Diagnostic Medical Imaging, Inc. and medical services provided to patient directly to the patient and the patient’s attorneys and other professionals who contact Advanced Diagnostic Medical Imaging, Inc. even if such statements or invoices are not requested. The undersigned patient agrees and directs Advanced Diagnostic Medical Imaging, Inc. to send to patient and patient’s attorneys gross, total, balance and other statements and invoices, and patient agrees to cooperate with and assist Advanced Diagnostic Medical Imaging, Inc. in the collection of all of Advanced Diagnostic Medical Imaging, Inc.’s statements and invoices. The undersigned patient specifically agrees that Advanced Diagnostic Medical Imaging, Inc. is authorized to mail or otherwise send billing statements and invoices and related correspondence directly to the patient and patient agrees that these invoices and billing statements may be used for the purposes of collecting a debt from patient, patient’s attorneys or other third parties. The undersigned patient specifically waives any claim or defense against Advanced Diagnostic Medical Imaging, Inc. and their respective agents and attorneys that the mailing or sending of the above-described invoices, statements and/or related correspondence violate any state or federal statute, including but not limited to Chapter 559, *Florida Statutes*, and the Fair Debt Credit Collection Act. The undersigned patient specifically agrees that he has agreed to the disclosure by Advanced Diagnostic Medical Imaging, Inc. and their respective agents and attorneys of all such invoices, billing statements and related correspondence. The undersigned patient hereby agrees to indemnify and hold harmless Advanced Diagnostic Medical Imaging, Inc. and their respective agents from any and all claims by patient or patient’s agents or any other third party for sending such invoices, billing statements and related correspondence, including any claims that such actions violate any state or federal statute, including but not limited to Chapter 559, *Florida Statutes*, and the Fair Debt Credit Collection Act. Patient agrees and hereby directs patient’s attorney to fully cooperate with and assist Advanced Diagnostic Medical Imaging, Inc. in collecting all such billing statements and invoices, including contacting third party payors to arrange for payment of Advanced Diagnostic Medical Imaging, Inc.’s statements and invoices.

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Patient/Guardian/Heath Surrogate Printed Name

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Signature Date

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Witness Date