Your health. **Your Choice**. Your MRI.

SCHOOL INSURANCE FILING

Date_______________

Name____

Angelo MRI will submit the cost of our services to your school insurance company. However, please be aware that some injuries are considered ***Non-Covered***. If your injury is not covered, you, your parent, or legal guardian will be responsible for the amount due. Your signature acknowledges that you understand this possible financial responsibility.

Estimated amount owed if school insurance does not pay __________________________________

____
Patient Signature

____
Printed Name

____
Parent/Legal Guardian Signature

____
Relationship to Patient