



"The Leader in Quality Medical Imaging"

Patient Financial Responsibility

As a courtesy to our patients, we have enrolled in numerous managed care insurance programs. We are pleased to be able to provide this service to you, and we will make every effort to verify coverage and bill your insurance company correctly. However, it is not possible for us to keep track of all the individual requirements of each plan.

It is the responsibility of each patient to notify our office of any changes to name, address or phone number and to know the details of his or her insurance plan in addition to any lapses in insurance coverage. Any charges that occur as a result of insurance plan restrictions or lapses in coverage are ultimately that patient's responsibility. Unfortunately, if you do not inform us of special requirements required by your plan and we order medically necessary services, such as lab work or supplies that are not covered by your plan; we may bill you directly for those charges. If current coverage cannot be verified prior to each appointment, payment will be due at the time of service. Payment of co-pay's are required prior to services being rendered. Any patient responsibility that is not paid within 90 days from the date billed may be assessed a 2 ½ % interest of the total amount due.

Providing the highest quality of medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance guidelines, whenever possible. With your cooperation you should be able to receive all the insurance benefits you are entitled to, and we will be able to focus our efforts on striving to provide you with excellent medical care.

BY SIGNING BELOW I ACKNOWLEDGE I HAVE READ AND UNDERSTAND THE FOLLOWING POLICIES AND I ACCEPT THE RIGHTS AND RESPONSIBILITIES OUTLINED WITHIN THEM:

- Patients Rights Regarding Medical Records
- HIPAA - Confidentiality and Privacy of Medical Records
- Patient Financial Responsibility

I hereby authorize the physician to release any and all information necessary concerning my diagnosis and treatment for the purposes of securing payment from my insurance company; and thereby authorize payment of the insurance benefits directly to the physician for any services rendered that are not paid for directly by me.

Patient Print

Date

Patient Signature

Name/Relationship
(if signed by individual other than patient)

** Copies of each policy available upon request.