ADVANCED IMAGING CONDITIONS FOR SERVICE

In order to reduce confusion and misunderstanding between patients and the practice, we have adopted the following conditions for service and financial policy. If you have any questions, please discuss them with our staff.

We do not participate in all health plans. If you have any questions or concerns, please ask us and we will assist you.

CONDITIONS FOR SERVICE

- ❖ The patient is under the control of his attending healthcare provider and the clinic is not liable for any act or omission in following the instructions of said healthcare provider. The undersigned consents to and authorizes the administration and performance of diagnostic or therapeutic procedures that are necessary or helpful in carrying out treatment that in the judgment of the attending healthcare provider may be considered necessary and advisable. This paragraph does not preclude the taking of special consents that may be required.

- ❖ Personal valuables: It is understood and agreed that the clinic maintains an area for the safekeeping of money and valuables and the clinic shall not be liable for the loss or damage of these items.

FINANCIAL POLICY

- ➢ We will bill your insurance. In the event you have no insurance we accept VISA, MasterCard, checks and cash.

- ➢ Payment arrangements can be made if you are unable to make full payment.

- ➢ We will bill third party liability insurance carriers once as a courtesy, if complete information is provided at the time of service. If the balance is not paid within 60 days it is the responsibility of the patient.

- ➢ Some health plans require pre-authorization for services in order to be paid. It is the patients responsibility to verify and obtain pre-authorization prior to services being rendered.

- ➢ Your insurance policy is a contract between you and your insurance company. As a courtesy we will file your insurance claim if you assign benefits to the facility. In other words, you agree to have your insurance company pay the facility directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive payment from your insurance carrier we will refund any overpayment to you.

- ➢ We have contracts with several carriers and will bill them directly. You will receive a bill for any balance due when we receive payment or denial from your company. The balance is due within 30 days of the insurance carrier's payment or denial.

- ➢ I understand that I am responsible for all charges incurred regardless of insurance or third party liability. We will accept patients as Medicaid if proof of coverage is presented at the time of service. Payment for CHIP patients is waived if verification of coverage is presented at the time of service.

- ➢ All health plans are not the same and do not cover the same services. In the event your health insurance determines a service to be "not covered" you will be responsible for the complete charge. Payment is due within 30 days of the denial.

- ➢ For services provided to minor patients, we will look to the adult accompanying the patient or guardian with custody for payment. We will not get involved in payment disputes between custodial and non-custodial parents.

I have read and understand the conditions for service and the financial policy.

I authorize this office (and its affiliates) to release any information necessary to expedite insurance claims. I understand that I am responsible for all charges, regardless of insurance coverage. I authorize payment of medical benefits to the above medical office (and its affiliates) for services provided. I authorize this office to release records to any physician that I may be referred to and any billing services for adjudication of claims. Permission is hereby granted to the medical office or its representative to obtain x-ray films or copies for any medical records which are pertinent to this service. I hereby agree that the above information provided by me is accurate and correct.

_____   _____   _____
Signature of patient/parent/guardian if signing for minor   Date   Relationship