DIAGNOSTIC IMAGING, P.C.

Date _________**Patient Name**_______________________________________**Chart #**__________

Financial Policy

1. As a courtesy to our patients, we file both primary and secondary insurance claims and we are committed to help each patient obtain the maximum allowable benefit from the insurance company.
2. Each patient is financially responsible for any amount not covered by their insurance policy, if applicable, including but not limited to, the amount of any co-payment and / or deductible. Patients who are entitled to Medicare benefits are financially responsible for the amount of any applicable co-payment and / or deductible.
3. Payment in full of each patient's account balance must be made within 60 days of service even if the insurance carrier has not paid the claim by that time. If timely payment is a problem due to personal financial difficulties, we will be happy to arrange an acceptable payment plan.
4. Acceptable forms of payment include cash, check or credit card.

I have read and understand the financial policy of **Diagnostic Imaging, P.C.** I further understand that I am financially responsible for payment of services provided by **Diagnostic Imaging, P.C.**

Signature ____**Date**_________________

Consent for Release of Info and Authorization for Payment

I hereby provide consent for Diagnostic Imaging, P.C. to release my protected health information for payment. Additionally, I request that payment of authorized insurance benefits (including Medicare benefits, if applicable) be made on my behalf to Diagnostic Imaging, P.C. for any services furnished to me by Diagnostic Imaging, P.C. I authorize Diagnostic Imaging, P.C. to release medical information about me to my Insurance Carrier and/or Center for Medicare and Medicaid Services, if applicable and its agents to the extent necessary or desirable to determine these benefits or benefits payable for related services.

Signature ____**Date**_________________