

NEXT GENERATION IMAGING, LLC
FINANCIAL POLICY

Name: _____

Date: _____

Social Security#: _____

Date of Birth: _____

The following is our financial policy which we require you to read and sign prior to any treatment:

Regarding Insurance: Insurance is billed as a courtesy to our patients. All balances are your responsibility whether your insurance company pays or not. Your insurance policy is a contract between you and your insurance company; we are not a party to that contract. Please be aware that some, and perhaps all, of the services provided may be non-covered and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. All copays and deductibles are due and will be collected at the time services are rendered.

Usual and Customary Rates: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Assignment of Benefits and Rights of Recovery:

I hereby authorize the use and release of any medical information necessary to process insurance claims on my behalf. I authorize payments of all medical benefits to Next Generation Imaging, LLC including major medical benefits to which I am entitled to under any insurance policy, under any self-funded program or any other benefit plan. I further agree to pay for any items that are not covered by my insurance company, if applicable. I understand that these items will be itemized by date of service and I will be billed after insurance, if applicable, is filed. I understand that if my insurance carrier has not paid the charges incurred upon my behalf in a reasonable amount of time, I will be held responsible for payment in full. I understand that if Workers Compensation or another carrier is liable for my bills, my group insurance is not responsible for payment. I understand that all information must be given to Next Generation Imaging, LLC before my appointment date in order to verify insurance coverage and liability. I am responsible for the amount charged after insurance has paid their portion and will be responsible for any court and collection fees that may be incurred in collection of the charged amount.

Past Due Accounts: In the event that my account becomes past due and is placed with a collection agency or an attorney, I have been advised and agree to pay any attorney or collection fees in addition to the account balance.

Authorization to Contact me: I authorize Next Generation Imaging to contact me, either by phone or by mail to provide a reminder of appointment, and/or information about any new technology or new services that Next Generation will be offering. Yes No

Acknowledgement of Receipt of Privacy Notice: I hereby acknowledge that Next Generation Imaging has provided me a copy of their Privacy Notice.

By signing below, I acknowledge that I have read and understand the above Financial Policy.

Print Patient Name

Patient Signature

Date

Print Witness Name

Witness' Signature

Date

y

y
