RADIOLOGY & MRI of Bethlehem, Inc.

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Financial Responsibility Form

Chart # _____

Patient Name _____ SS # _____

Address _____ Phone _____

_____ DOB _____

AS A MEDICAL PROVIDER, OUR RELATIONSHIP IS WITH YOU AND NOT YOUR INSURANCE COMPANY. IT IS YOUR RESPONSIBILITY TO KNOW YOUR POLICY. WE CAN ONLY TELL YOU OUR CHARGE, AMOUNT PAID AND AMOUNT OWED.

INSURANCE COVERAGE

- [X] It is your responsibility to be aware of your insurance coverage, policy provisions, exclusions and limitations as well as **pre-authorization requirements**. This information is furnished by the insurance carrier.
- [X] If your coverage is not in effect at the time of your visit, the financial responsibility for payment is yours.
- [X] If you have any changes in your insurance coverage, you must notify us.

DEDUCTIBLES, CO-PAYMENTS, CO-INSURANCE & NON-COVERED SERVICES

- [X] **Deductibles** are the patient's responsibility. The deductible is determined by the contract you have with your insurance carrier. We do not know how much each person's deductible is and how much has been met at the time of your visit.
- [X] **Co-payments** and **co-insurance** are the patient's responsibility.
- [X] All patients are responsible for **"non-covered" services** if denied by their insurance carrier.

REFERRALS

☒ It is your responsibility to obtain referrals if required to do so by your plan.

INSURANCE REQUESTS

☒ You are responsible for responding to any request from the insurance company for further information. Not doing so will result in a claim denial and you will be responsible for payment.

INSURANCE PAYMENTS SENT TO YOU

☒ If insurance payments are sent to you, you are responsible for forwarding them to our office with a copy of the explanation of Benefits (EOB) received.

There will be a $30.00 charge if your check is returned for non-payment by your bank.

I have read and understand this Financial Responsibility Form.

Patient Signature _____ Date _____

Parent/Guardian Signature _____ Date _____