Your health. **Your Choice.** Your MRI.

FINANCIAL RESPONSIBILITY

FINANCIAL RESPONSIBILITY, IF DIFFERENT FROM PATIENT:

Name _____ Relationship _____
Social Security Number _____ Date of birth _____
Address _____ City/State/Zip _____
Telephone: Home _____ Work _____Cell _____
Employer _____
Employer address _____

INSURANCE INFORMATION:

Primary insurance company_____
Policy ID _____ Group name _____
Policyholder name _____ Insurance phone number_____

Secondary insurance company_____
Policy ID _____ Group name _____
Policyholder name _____ Insurance phone number_____

Tertiary insurance company_____
Policy ID _____ Group name _____
Policyholder name _____ Insurance phone number_____

FINANCIAL RESPONSIBILITY:

I understand that all medical charges incurred by me, or by my dependents, for services rendered are my financial responsibility and that all fees necessary to collect this amount are payable by me. Also, I understand that I am responsible for payment of any deductible, co-payments, and non-covered services.

Although Angelo MRI may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. Therefore, you will be responsible to pay any portion of the charges not covered by insurance.

I hereby assign all medical benefits to which I might be entitled, including Medicare, Private Insurance, Liability, Worker's Compensation and all other health plans to Angelo MRI, for services provided and not yet paid in full. I understand that insurance is a contract between me and my insurance carrier and that, in the event that my insurance company fails to make payments for services rendered within sixty (60) days of billing, I will be personally responsible for the fee. If this account is turned over to a collection agency, I will be responsible for all collection fees, court costs, reasonable attorney's fees, interest, and any other charges regarding the collection of the balance.

_____

Patient/Parent/Legal Guardian Signature

_____

Printed Name

_____

Relationship to Patient