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

FINANCIAL RESPONSIBILITY

FINANCIAL RESPONSIBILITY, IF DIFFERENT FROM PATIENT:

Name _____ Relationship _____
Address _____ City/State/Zip _____
Telephone: Home _____ Work _____Cell _____

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 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

_____
Relationship to Patient