FREDERICK RADIOLOGY
Diagnostic Center
1003 West 7th Street, Suite 1001 • Frederick, MD 21701
(240) 439-4405 phone • (240) 439-4895 fax
Fradiology@yahoo.com email

PATIENT FINANCIAL AGREEMENT

I hear by authorize *Frederick Radiology & Diagnostic Center* to apply for benefits on my behalf for services rendered. I authorize the release of any necessary information, including medical information, for this or any related claim to my insurance company in order to determine these benefits payable. I request that payment of authorized benefits be made payable to Frederick Radiology & Diagnostic Center on my behalf.

1.) We participate with Medicare, Carefirst BCBS and certain HMO/ PPO programs. Please confirm with your insurance company that we are listed as participating providers. By contract, covered charges will be paid directly to us by your insurance company. Any applicable co- insurance and deductible payments will be billed.

2.) If we do not participate with your insurance you will be required to pay in full for charges at the time of service. As a courtesy, we will submit the insurance form on your behalf requesting that the payment be made directly to you for reimbursement.

3.) If a referral or authorization is deemed necessary by your insurance, you are responsible for obtaining one from your referring doctor and presenting it to Frederick Radiology & Diagnostic Center for claim filing purposes. If the claim is denied due to an invalid and/ or missing referral/ authorization, you will be held responsible for the charges.

4.) A $25.00 fee will be charged to all patients for any returned checks.

5.) I understand that I am financially responsible for any non-covered and/ or denied charges incurred on my behalf.

6.) If my account becomes assigned to a collection agency, I agree to pay collection agency fees, all court costs, and attorney fees. I understand that all accounts with a balance over 30 days could be assessed with a late charge on the unpaid balance.

7.) I have also reviewed or been provided with a copy of Frederick Radiology & Diagnostic Center's Notice of Privacy Practices.

8.) A copy of this agreement may be used in place of the original.

Printed Name: _____

Signature (SEAL): _____ **Date:** _____