

Frederick Radiology & Diagnostic Center

PATIENT FINANCIAL AGREEMENT

I hereby 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 to determine these benefits payable. I request that payment of authorized benefits be made payable to Frederick Radiology & Diagnostic Center on my behalf.

1.) I understand that Frederick Radiology & Diagnostic Center participates with most insurances including Medicare, Carefirst BCBS and certain HMO/ PPO programs. I understand that by contract, covered charges will be paid directly to Frederick Radiology & Diagnostic Center by my insurance company. I understand that any applicable co-insurance and deductible payments will be billed to me or paid at time of service.

2.) I understand that if I choose to waive my insurance benefits, I will be required to pay in full for charges at the time of service or to have an approved payment plan put in place by Frederick Radiology & Diagnostic Center.

3.) I understand that if an authorization is deemed necessary by my insurance, Frederick Radiology & Diagnostic Center will obtain that authorization. If the claim is denied due to an invalid referral, I understand that I will be held responsible for the charges.

4.) I understand that a \$30.00 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.) I certify that a copy of this agreement may be used in place of the original.

Printed Name: _____

Signature (SEAL): _____ Date: _____