

# OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered to be a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment. All patients who do not pay in full at the time of service must complete our information and insurance form before services are rendered. This center is a division of North Atlanta Scan Associates, Inc. Professional services are being rendered by a physician who is an independent contractor separate from North Atlanta Scan Associates, Inc...

## PAYMENT POLICY:

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, AMERICAN EXPRESS AND DISCOVER.

WE ACCEPT AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL.

WE CHARGE A 1.5 % MONTHLY INTEREST RATE ON ALL BALANCES OVER 60 DAYS PAST DUE.

WE CHARGE A ONE TIME \$15.00 LATE FEE (NO INTEREST IS CHARGED ON THIS FEE)

WE CHARGE A \$30 FEE FOR RETURNED CHECKS

**WE CHARGE A \$25 PROCESSING FEE FOR NON-PAYMENT OF CO-PAYMENT/PATIENT PAYMENT AGREEMENTS**

**(Fee waived if post-dated checks given or monthly credit card charge)**

## REGARDING INSURANCE

**FULL PAYMENT OF ESTIMATED DEDUCTIBLE AND CO-PAYMENTS ARE EXPECTED AT THE TIME OF SERVICE**

We may accept assignment of insurance benefits for your visit. However, we do require that any unmet deductible and/or co-payments be paid at the time of service. The balance is your responsibility, whether your insurance company pays or not. We will bill your insurance company when you give us the required insurance information. Your contract is between you and your Insurance Carrier. Although we will assist you with your claim by a courtesy filing you should contact your insurance regarding payment of a claim. Therefore, if your insurance company has not paid your account in full within forty-five (45) days, we require that you remit the full balance due yourself. Should your insurance pay less than you expected, or not at all, it is your responsibility to confer with your carrier should you wish to dispute your claim. However, you are still obligated to remit your balance immediately.

## USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

## LIABILITY CASES

In the event you are relying on court settlement to cover your medical expenses, our practice requires complete attorney and claim information, as well as a lien with payment at time of service of one hundred dollars or 10% of the fee, whichever is greater. We also require information regarding other health information you may have. In all cases we require that you set up payment arrangements for the period of time your case is in litigation.

## ACCOUNTS REFERRED FOR COLLECTION

In the event your account is referred to a collection agency and/or attorney, you will be responsible for any additional expense incurred by North Atlanta Scan Associates, Inc. in the course of obtaining payment on your account including, but not limited to, court costs, collection agency and/or attorney fees. Any such costs will be added to your unpaid debt.

## IMAGE RELEASE POLICY

The following explains our policy for releasing images. By signing below you are acknowledging that you have read and understand our policy and authorize us to release your images to you and/or your doctor in accordance with the following:

In the event I or my doctor may wish to borrow my images, it is my understanding that these are original images and are a part of my medical record which will be released on loan. It is understood that loss of original images means permanent loss of information. Therefore I will take full responsibility to see that the images are returned and hereby release North Atlanta Scan Associates, Inc. from any liability should unreturned films be needed at a later date. I understand that my physician will have access to my images upon request. However, if I wish to have a copy for myself, I understand that there will be a cost of \$10.00 per sheet of film or \$15 per CD. Copies of any exam will include a complete set of images. **24 HOURS ADVANCE NOTICE IS REQUIRED TO FULFILL A REQUEST FOR IMAGE RELEASE AND/ OR COPIES. I UNDERSTAND THAT IF COPIES ARE REQUESTED AND NEVER PICKED UP I WILL BE CHARGED \$10.00 PER SHEET OF FILM OR \$15 PER CD. Images are not automatically sent to your doctor unless requested!**

\_\_\_\_\_ YES, I would wish to receive a copy for myself. \_\_\_\_\_ Film \$10.00 per sheet \_\_\_\_\_ CD (if available) \$15 per CD

\_\_\_\_\_ NO, I do not wish to receive a copy of my images at this time. (*Future requests subject to 24 HR advance notice*)

## AUTHORIZATION

I authorize North Atlanta Scan Associates, Inc. and it's centers to release any information required in the course of my examination or treatment. I authorize any physician or hospital to provide details of my medical history to North Atlanta Scan Associates, Inc. I permit a copy of this authorization to be used in place of the original and request payment of benefits to North Atlanta Scan Associates, Inc. However, I do acknowledge I am responsible for payment of all services regardless of insurance coverage.

***I have read the financial policy, I understand and agree to all of the terms of this document.***

\_\_\_\_\_  
Patient's Signature (or Parent/Guardian if applicable):

\_\_\_\_\_  
Date: