

PATIENT ID# : _____



DATE: _____

Financial Policy

All professional services rendered are charged to the patient. The patient is responsible for all fees regardless of insurance coverage. Payment for services is due at time of registration.

X _____
(Please Initial)

Insurance Authority & Assignment

I request that payment of authorized Medicare/Other Insurance Company benefits be made to Reno Diagnostic Centers for any services furnished me by that party who accepts assignment/physician. All regulations pertaining to Medicare assignment of benefits apply. Patients are responsible for all deductibles, co-insurance, and non-covered services, which is the charge determination of your insurance company.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or related Medicare claim/Other Insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment.

X _____
(Please Initial)

Acknowledgment of Notice of Privacy Practices

Use and disclosure of protected health information is regulated by a federal law known as The Health Insurance Portability and Accountability Act of 1996 (HIPAA). Under HIPAA, providers of healthcare are required to give patients an opportunity to review and/or obtain a copy of their Notice of Privacy Practices for Protected Health Information and make a good faith effort to obtain a written acknowledgment that this notice was received.

I acknowledge that Reno Diagnostic Centers has provided me with an opportunity to review and obtain a written copy of their Notice of Privacy Practices for Protected Health Information in accordance with federal HIPAA regulations.

X _____
(Please Initial)

I authorize the release of my films to the referring physician(s) and/or consulting physician(s) as requested.

X _____
(Please Initial)

NOTE: Refusal to sign or initial any part of this form does not necessarily negate patient's financial responsibility for services rendered nor disallow RDC from releasing information as outlined by our Notice of Privacy Practices or as required by law. Consent to receive services is considered to be an implied acknowledgment of and agreement with all notices and consents outlined above.

(If you are signing as a personal representative, documentation of your legal right to do so must be provided.)

X _____
Signature of patient or personal representative

Date

Printed name

Relationship to patient

FOR INTERNAL USE ONLY

We made a good faith effort to provide patient, _____, with a copy of our Notice of Privacy Practices and financial policy but we were not successful for the following reason:

Employee signature #1: _____

Employee signature #2: _____

Printed Name: _____

Printed Name: _____