Steinberg Diagnostic Medical Imaging (SDMI) Patient Financial Responsibility Policy

Dear Patient

Thank you for choosing us as your health care Imaging provider. Following is our Financial Policy. If you have any questions or concerns about our policy, please contact our billing office. Please read this document and provide your signature below attesting to the fact that you have read and understand the information contained herein.

Non-Insured or those choosing to not use insurance: Payment in full is due at time of check-in.

Insured Patients: Co-pays and deductibles are due at check-in. Also at this time notify staff if you have any secondary insurance.

We accept MasterCard, Discover, Visa, and/or American Express. **We do not accept cash or checks at the front desk.** You may use a check to send in money owed once you receive an invoice. There is a non-sufficient–funds (NSF) charge of $25.00 if your check doesn't clear our bank due to lack of funds.

Please understand that any money collected is only an estimate based on current information. Once your account is billed out to the insurance company the amount paid may differ from what is actually owed.

No shows may be subject to a 50.00 no show fee. Nuclear medicine patients will be responsible for the cost of the dose that was wasted due to a no show. Some of these doses can cost thousands of dollars.

If your insurance company does not pay within 30 days, please contact them to help move the payment along.

All insured patients must sign this financial policy to be seen at our offices.

If we are not paid, in accordance with our contracts with the insurance companies, within 60 days, your account will be turned over to a collection agency. You will be responsible for any costs, interest, court costs, or any other fees associated with collecting the debt. Any information in our system that may be legally turned over to the collection agency to help in collecting the debt will be turned over. If you have a credit balance, it may be applied to money owed for other visits.

Assignment and Transfer of Benefits

I hereby guarantee payment of all charges incurred at the offices of Steinberg Diagnostic Medical Imaging. I hereby transfer and direct to pay any and all benefits for medical services provided by SDMI directly to SDMI. I hereby authorize the release of medical information required to process my claim.

I have read and agree to the terms spelled out in this document. I understand that this assignment applies to all services received at SDMI and will remain in effect until specifically revoked in writing. I further agree that I am ultimately responsible for payment of all charges incurred should my insurance company fail to pay.

Signature of patient or financially responsible person _____Date_____

Reason Patient unable to sign _____

Relationship to Patient _____