NOTIFICATION REGARDING FINANCIAL RESPONSIBILITY FOR MEDICAL SERVICES

1. I understand and acknowledge that my Insurers will only pay for services that they determine to meet their coverage requirements and benefit terms.

2. As examples: some insurers require prior authorization for certain services. Some insurers have decision-makers that disagree with the medical necessity of certain recommended treatments, tests or examinations.

3. If my Insurer determines that the services or any part of them are not medically necessary, or fail to meet other coverage requirements (such as obtaining authorization or filing a claim in a limited time), the Insurer may deny payment for that service.

4. I agree that if my Insurer denies all or any part of the Provider's charges for any reason, or if I'm not eligible at the time of service, I will be personally and fully responsible for payment of Provider's charges. Should my account be referred to an attorney or collection agency, I agree to pay actual attorney fees and collection expenses. All delinquent accounts shall bear interest at twelve percent per annum, not to exceed the maximum amount permitted by law.

5. Deductions and Copays cannot always be predicted at the time of service, as patients' benefits can change throughout the year. It is the responsibility of the patient/payee to communicate directly with their insurance carrier to determine the final cost of the service.

6. The undersigned certifies that he/she has read and understands the information above, and is the patient, or the person financially responsible for the patient's treatment needs, and is duly authorized to sign this document.

Name: ________________________________ Date: ____________________

Signature: ______________________________

Carlsbad Imaging Center

Imperial Radiology