



IMAGE NORTH
Advanced Radiology Specialists

ASSIGNMENT OF BENEFITS

Patient Name: _____ Date: _____

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to the physicians of Image North, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the physicians of Image North to release all information necessary to secure the payment of benefits. I authorize use of this signature on all insurance submissions.

FINANCIAL POLICY

If medical insurance information is received at that time of service, as a courtesy, a claim will be submitted to your company. Insurance co-payments and annual deductibles not met for the year are payable when services are rendered. Any services that are not fully reimbursed by your insurance and are indicated on your insurance's Explanation of Benefits to be the patient's responsibility will be due and payable upon receipt of a billing statement. Unless you are covered by a government program (Medicare, Medicaid, Worker's Compensation and No Fault Insurance, etc.) or a private insurance that has an agreement that prohibits members from being billed and if correct insurance information or referral documentation is not presented at the time of service, you are responsible for the full amount of charges incurred. Also, please be aware that this center will not forgive patient deductibles, patient co-payments, and patient co-insurance payments due. It is against the law.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I hereby acknowledge receipt of Image North's Notice of Privacy Practices, which I have reviewed, and give my permission to them to use and disclose my information in accordance with it.

Signature of Patient

Signature of Patient's Representative

Name of Patient (Print)

Relationship of Representative of Patient

Date

Date