



RADIOLOGY FINANCIAL POLICY

You are to have a diagnostic medical scan, which will be seen immediately by the staff physician who is working today. Radiologists at Medical Imaging Associates of Idaho Falls will supply the official diagnostic report of the scan. They will deliver their diagnosis to your physician. For their services, Medical Imaging Associates of Idaho Falls will bill you separately.

By signing below you are confirming that you have read, understand and agree to this Financial Policy. Your bill will be filed with your insurance provider. Please provide a copy of your insurance card to expedite the billing process.

INFORMATION RELEASE AND FINANCIAL AGREEMENT

I hereby authorize Medical Imaging Associates of Idaho Falls, PA along with any contracted billing service of Medical Imaging Assoc. of Idaho Falls, PA. to furnish my insurance carriers and/or any agency working in their behalf, and my primary care provider any and all medical information concerning my treatment and diagnosis pertaining to Medical Imaging Assoc. of Idaho Falls, PA services. I request that payment of authorized insurance benefits be made either to me or on my behalf to Medical Imaging Assoc. of Idaho Falls, PA. for services furnished me by that organization or their agents. I agree to pay any costs of collection not to exceed 50%, reasonable legal fees and court costs.

Date Policy Holder or Responsible Party SIGNATURE REQUIRED

MEDICARE PATIENTS ONLY

INFORMATION RELEASE AND FINANCIAL AGREEMENT

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Medical Imaging Associates of Idaho Falls, PA for any services furnished me by that organization or by their agents. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services, formally the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Date Policy Holder or Responsible Party SIGNATURE REQUIRED

MEDIGAP ASSIGNMENT AUTHORIZATION

Beneficiary: Medicare #: Medigap Policy #:

I request that payment of authorized Medigap benefits be made on my behalf to Medical Imaging Associates of Idaho Falls, PA for any services furnished by that organization. I authorize any holder of medical information about me to release to (Name of Medigap Policy) any information needed to determine these benefits.

Date Policy Holder or Responsible Party SIGNATURE REQUIRED

Questions regarding your bill from Medical Imaging Associates of Idaho Falls can be directed to 523-4906.