CAROLINA OMF IMAGING

Combining Advanced Diagnostics With Knowledge and Experience

# Our Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require you to read and sign prior to any medical services being rendered.

1. Full payment is due at the time of service.
2. We accept Cash, Visa, Mastercard, and Discover.
3. As a courtesy to our patients, we will submit your medical insurance on your behalf.
4. As of **January 1, 2007** we no longer participate (Or File Claims) with Medicare, therefore, we do not file a claim or any other (secondary) medical insurance you may carry.

## REGARDING INSURANCE

We do not accept assignment of your insurance benefits. You will be responsible for payment at the time the services are rendered. Your insurance policy is a contract between you and your company; we are not a party to that contract. We are not in-network providers with any insurance plan.

Please be aware that some, and perhaps all of the services provided may be deemed non-covered services or not medically necessary under Medicare and/or other medical insurance programs.

## USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment to our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

## MINOR PATIENTS

The adult/parent accompanying the minor is responsible for payment of the minor patient's account, regardless of who the insurance policyholder is. For unaccompanied minors, non-emergency treatment will be denied unless the minor is prepared to pay when services are rendered.

I authorize Carolina OMF Imaging LLC to release any information, including the diagnosis and records of any treatment(s) or examination(s) rendered to me or my child to my insurance company(s) necessary to process claims. I also authorize and request my insurance company(s) to make payment of any medical benefits directly to the physician or Carolina OMF Imaging LLC.

**THANK YOU FOR UNDERSTANDING THE NECESSITY OF OUR FINANCIAL POLICY, PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS OR CONCERNS REGARDING THE ABOVE FINANCIAL POLICY.**

**I HAVE READ, UNDERSTAND, AND AGREE TO THIS FINANCIAL POLICY.**

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Signature of Patient (if patient is under 18-parent or guardian must sign) Today's Date