FINANCIAL ARRANGEMENT FORM

Welcome to our office. We require all patients to show their insurance or managed care membership card, and their driver's license, so that we may make copies for our permanent record.

I consent to treatment necessary for the care of (patient) ____.
(Name and Signature)

Or, if patient is a minor:____
Signature of (parent and guardian)

FINANCIAL ARRANGEMENTS

At the time of service, you are responsible for your percentage (co-payment) plus any deductible. If your insurance company has not paid in 45 days, the balance at that time is your responsibility. I acknowledge full financial responsibility for services rendered by Dalton Imaging Center for the above name patient:

Signature: ____
(Last Name) (First) (Middle)

SSN: ____ Relationship to Patient: __________________________

Address: _____________________________________ City: ___________ State: ______ Zip: ___________

Home Phone:_____________________________________ Business Phone: ____________________________

Employer: ____

Address: _____________________________________ City: ___________ State: ______ Zip: ___________

Plan Number: ____________________________________ Shift Worked:______________________________

I understand that payment of charges incurred is due at time of service unless other financial arrangements have been made prior to treatment.

CREDIT CARD INFORMATION

I acknowledge full financial responsibility for services rendered by Dalton Imaging Center, and authorize transfer of all unpaid amounts to my VISA/MasterCard/Discover after 45 days from date of service for any dollar amount owed by not to exceed $_______________________________.

Circle One: ❑ VISA ❑ MasterCard ❑ Discover Name on Card: ______________________________________

Card Number: ____ Expiration Date:________________

I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges. All accounts are due and payable by 45 days from date of service. Finance charge of 1-1/2% per month which is annual percentage rate of 18% charged on all past due accounts. I further authorize and request that insurance payment be made directly to Dalton Imaging Center should they elect to receive such payments. I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

Signature: ____ Date: _________________________