RHODE ISLAND **MEDICAL IMAGING**

Patient Financial Policy for all Services Rendered in 2020

Participating Insurance

- Rhode Island Medical Imaging participates with most medical insurance plans in the area.
- We will file a claim on your behalf and accept contracted payments for covered services.
- You are responsible to pay for all plan deductibles, coinsurances, co-payments and non-covered services associated with the service rendered. (out of pocket expenses)
- It is your responsibility to contact your insurance and understand your benefits.

Non-Participating Insurance

- If Rhode Island Medical Imaging does not participate with your insurance, you are responsible for payment of all charges associated with the services you received.

No Insurance

- Payment in full is expected at time of service.

Outstanding Balances

- Patients with an outstanding balance with Rhode Island Medical Imaging will be expected to pay that balance at the time of their scheduled exam.
- This may include balances due for services provided by our physicians at all of our hospital affiliates.

Payment Policy

- If a payment is not made within 30 days of your first billing statement, your account may be referred to an outside collection agency.

Credit Card Policy

- I authorize Rhode Island Medical Imaging to securely store my credit card information, and only charge it should I have an outstanding balance or any leftover balance from a claim processed in the future.

Message Authorization

- I authorize Rhode Island Medical Imaging to text, e-mail, or leave phone messages for me regarding upcoming appointments, procedures and billing information.

The patient may have their report or CD upon request.

Patient Financial Services representatives are available on weekdays from 7:30am to 6:00pm; please call (401) 432-2500.

We accept MasterCard, Visa, American Express, Discover, personal checks, and cash.

Please Read and Sign Below

I have read, understand and agree to this financial policy. I authorize the release of any medical or demographic information necessary to process services for payment. I understand that by signing this document it pertains to all services provided by Rhode Island Medical Imaging during this calendar year.

_____ _____ _____

Signature of patient or responsible party Date Account #

DIAGNOSTIC IMAGING
CENTER *of* EXCELLENCE™

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Thank you for choosing Rhode Island Medical Imaging.