



# RHODE ISLAND MEDICAL IMAGING

## Patient Financial Policy for all Services Rendered in 2021

### 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, co-insurance, co-payments and non-covered services associated with the exam rendered at the time of service. (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 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. You may also pay directly from your cell phone upon receipt of text message.

### 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 #

**Thank you for choosing Rhode Island Medical Imaging.**



02/01/2021 kb