Grossman Imaging Center

P.O. Box 6305;Oxnard, CA 93031-6505; 805-988-0616

Unless prior arrangements have been made with this office, ALL fees are due from ALL PATIENTS as services are rendered.

PATIENTS WITH INSURANCE

As a courtesy with private Health Care Insurance we do complete and file claims with the appropriate insurance companies, however, all patients are kindly requested to understand that the financial responsibility for our services will remain theirs – the patients – and not their insurance companies. Even though an insurance claim is filed on the patient's behalf, this office cannot accept responsibility for collecting the claim nor can it get involved in negotiating settlement on a disputed claim. Pre-authorization for your procedure from your insurance company does not guarantee payment. Payment of our fees is at all times the sole responsibility of the patient.

PATIENTS WITH MEDICARE

It is the policy of this office to "accept assignment" on all claims submitted to Medicare on behalf of our patients. This means that we will file a claim with Medicare on the patient's behalf and look for payment directly from Medicare for 80% of the allowed fees and then bill the patient for the balance of 20% of the fees allowed by Medicare. The 20% balance is due and payable by the patient immediately upon receipt of our statement. If you have assigned your Medicare benefits over to an HMO your Medicare benefits are no longer valid at this office. Please let our receptionist know before your procedure.

CONSENT FOR TREATMENT

I hereby consent to examination and treatment deemed advisable by the professional staff of Grossman Imaging Center, and I agree that all records are and shall remain the property of Grossman Imaging Center. I authorize, however Grossman Imaging Center to furnish any information requested by an insurance company of the patient.

FINANCIAL RESPONSIBILITY

I, the undersigned, do hereby assume full responsibility for the payment of services rendered to this patient. Furthermore, I assign my insurance benefits, in connection with all services rendered to Grossman Imaging Center. I understand that I shall be responsible for any service that is not covered in part or as a whole by my insurance.

Should the account be referred to collections the undersigned shall pay reasonable attorney fees and collections expenses. All delinquent accounts shall bear interest at the legal rate.

The undersigned certifies that he/she read the forgoing, and has received a copy thereof and furthermore attests that he/she is either the patient or an authorized representative of the patient to execute this form and accept its terms.

Charges $__________ ______________________________ __________
Patient Date

Add'l Ch $__________ ______________________________ __________
Patient's Agent or Representative Date

Pmt on Acct $__________ ______________________________ __________
Relationship to Patient

Balance Due $__________ ______________________________ __________
Witness Date