



Financial Policy for Midwest NeuroImaging Center

Thank you for choosing Midwest Imaging Center. The following is a statement of our FINANCIAL POLICY. All patients must accept our financial policy guidelines before receiving treatment. Please understand that full payment of your bill is considered a part of our treatment.

REGARDING YOUR INSURANCE: As a courtesy to you, we will submit medical claims to your insurance company. **Any balance after processing of our claim by your carrier is your responsibility.** Your insurance policy is a contract between you and your insurance company. **You are responsible for verifying if providers are in-network with your insurance company.** We cannot bill your insurance company unless you give us your complete insurance information for commercial insurance, Medicare and Nebraska & Iowa Medicaid. It is your responsibility to know your insurance benefits, it may not cover all of the services provided to you.

SELF-PAY PATIENTS: **X-rays need to be Paid in Full at the time of service.** Financial arrangements will need to be made PRIOR to any MRI or CT Scans ordered. Failure to comply with this will result in cancellation of your appointment.

WORKERS COMPENSATION: All workers compensation visits **must be authorized BEFORE your visit,** if this is not done, your appointment will be cancelled. You must provide us with the responsible party's information, including their name, address, phone number, claim number and date of injury. If this information is not provided at the time of service, you are responsible for this balance, which is expected to be paid within 30 days to avoid further collection activity.

PERSONAL INJURY: All radiological services provided by Midwest NeuroImaging will require 50% down payment, unless other arrangements have been made prior to your visit here. We do not bill attorneys.

METHOD OF PAYMENT: We accept Cash, Check, Visa and MasterCard. Payment plans may be arranged on an individual basis with the Billing Department in our office. **All co-pays are due prior to treatment.**

COLLECTIONS: We reserve the right to forward your account to a collection agency if it is determined to be uncollectible. An administrative fee of \$10.00 will be applied to your account if it is turned over.

I have read, understand, and agree to the above financial policy for payment of professional fees. I understand the patient is ultimately responsible for all professional fees.

Patient Signature _____

Date: _____

DEFINITIONS below are defined by your Health Plan & the financial responsibility of the patient or guarantor.



- **COPAYMENT:** A fixed dollar amount set by your insurance contract that is to be paid at the time of an office visit.
- **DEDUCTIBLE:** An annual dollar amount established by your insurance plan that is deducted from insurance benefit.
- **CO-INSURANCE:** A percent set by your insurance plan that is deducted from insurance benefits. Usually 10%-30%.