Dakota RADIOLOGY

* D R F I N A G *

Patient Last Name: _____

First Name: _____

Date of Birth: _____

Patient MRN#: _____

Financial Responsibility Agreement

1. **Patient Portion Due at Time of Service.** The Undersigned, whether as patient or as agent, acknowledges all co-payments must be paid at time of service. This arrangement is part of the patient's contract with his or her insurance company. For procedures, the Undersigned will be asked to pay a co-insurance and deductible. Upon request, an estimate of services will be given prior to the service being performed.

2. **Insurance and Claims Submission.** The Undersigned, whether as patient or as agent, understands Dakota Radiology will submit insurance claims to most insurance companies; however, if Dakota Radiology does not participate with the patient's insurance plan, it will be the responsibility of the Undersigned to pay-in-full at time of service. The Undersigned should be aware that some or all of the services may be non-covered by insurers, and many insurance companies require pre-authorization for various procedures. Dakota Radiology will assist in obtaining the necessary pre-authorizations when needed; however, it is the responsibility of the Undersigned to determine if the patient's insurance company requires one. Failure to obtain the necessary pre-authorization or second opinion may result in a reduction or denial of benefits by the insurance company, which would result in the requirement of the Undersigned to pay the full amount due. For employer-requested services, Dakota Radiology will confirm pre-authorization and guarantee of payment prior to the service being rendered.

3. **Assignment of Insurance Benefits.** If the patient's care is covered by insurance, the Undersigned agrees the insurance company is to pay Dakota Radiology directly for the patient's care. Additionally, certain physicians (e.g., anesthesiologists, oncologists, pathologists, and radiologists) may participate in the patient's care. These physicians are not employees or agents of Dakota Radiology, and they will bill separately for their care. The person signing this form, whether he or she is the patient or signing for the patient, authorizes direct payment to Dakota Radiology and / or the physicians of any insurance benefits, settlements, or awards otherwise payable for this outpatient service (including emergency services if rendered) at a rate not to exceed the respective charges of Dakota Radiology and / or the physicians. The Undersigned understands he or she is financially responsible for charges not paid by insurance or any other third-party payor.

4. **Promise to Pay Account.** The Undersigned agrees that he or she will pay for the care the patient receives. The person signing this document, whether he or she is the patient or is signing for the patient, agrees that he or she personally obligates himself or herself to pay the account charges in accordance with the rates and polices of Dakota Radiology. If the patient is uninsured or has a large deductible, payment arrangements can be made with a Dakota Radiology Patient Financial Counselor. The Undersigned also agrees that Dakota Radiology may assess interest on any unpaid balance at a rate not to exceed the maximum statutory amount per year.

5. **Guarantee of Account.** The Undersigned understands that Dakota Radiology must be paid for the care the patient receives. The Undersigned may expect that someone else is going to pay for the patient's care, as there may be insurance coverage, or the patient may have been injured due to someone else's negligence, or there may be other circumstances; however, the Undersigned agrees to be personally-responsible for paying for the care received. Even if the Undersigned believes another party is obligated to pay for the care, he or she still agrees to personally guarantee Dakota Radiology will be paid for the care the patient receives. Therefore, the person signing this document, whether he or she is the patient or is signing for the patient, agrees that he or she personally obligates himself or herself to pay the charges in accordance with the rates and policies of Dakota Radiology. He or she agrees that Dakota Radiology may assess interest on any unpaid balance at a rate not to exceed the maximum statutory allowable interest rate per year.

6. **Minor Patients.** The Undersigned understands that the parent or guardian accompanying a minor is responsible for payment. An unaccompanied minor will not be seen without a minor consent form signed by the parent or guardian, and the minor must bring his or her co-payment or patient portion due at the time of service.

Patient, Parent, Guardian, Agent Name: (Signature): _____ Date: _____ Time: _____

Patient Name: (PRINT) _____

If other than the patient,
indicate your relationship to the patient and print your name: _____

Witness (1) Name PRINT and SIGN: _____ Date: _____ Time: _____

Witness (2) Name PRINT and SIGN: _____ Date: _____ Time: _____

(2 witnesses needed for emergent situations in the ED or verbal consents only)