FINANCIAL AND INSURANCE POLICY

Zoom Diagnostic Imaging's fees are established according to services performed and payment is due when services are rendered. Should your account be referred for collections you will incur a 25% collection fee that is based on your unpaid balance. If this balance remains unpaid and we were forced to pursue litigation the fee increases to 40%. In the event there is a credit balance on your account greater than $5.00 this will be refunded to you in the manner in which the original payment was made. A credit balance of less than $5.00 will remain on the account to be applied to any future services. If you've paid your estimated out of pocket via check and this is returned for insufficient funds, there will be a fee of $30.00 added to your account.

Zoom Diagnostic Imaging may or may not be participating with your insurance plan. Every attempt will be made to determine your financial responsibility; however, this is often limited by the information your insurance company will provide to us. Your estimated financial responsibility is due in full at the time of service. The information provided to Zoom Diagnostic Imaging by your insurance may be provided to you upon request. In some instances your insurance plan will require a prior authorization for services. Zoom Diagnostic Imaging will work with your insurance company to obtain this authorization prior to any services rendered. In some instances, your insurance plan will require medical documentation and/or information we do not have access to. In those instances, you will be given the option to contact your referring provider to obtain the authorization or proceed with the scan as a self-pay patient. At no point will the information received from insurance be considered a guarantee of coverage or payment by your insurance plan. Should the information provided by your insurance company be incorrect, financial responsibility will rest with the patient or guarantor of the account.

In consideration for services rendered or to be rendered I hereby irrevocably assign and transfer to Zoom Diagnostic Imaging, all rights, title, and interest, to the benefits payable by any and all third-party payers that are or may be liable for the services rendered to the patient. This irrevocable assignment and transfer shall allow Zoom to pursue any such right of recovery. Even though I have made this assignment, I understand Zoom Diagnostic Imaging has the right to demand payment in full from me and I am responsible for payment for any charges not paid, on my behalf.

The undersigned hereby authorizes Zoom Diagnostic Imaging to release information to: the insurance company of record, medical assistance programs (including their agents, reps, or assignees), the Social Security Administration or its intermediaries, third party payers.

HIPPA ACKNOWLEDGEMENT

By signing this authorization, you acknowledge and agree that Zoom Diagnostic Imaging (Practice) or its Business Associates may use or disclose your Protected Health Information (PHI) for the purpose of providing treatment, for purposes relating to the payment of services rendered, and for the Practice's general healthcare operations purposes. For this consent, PHI means any information, including your demographic information created or received by the Practice, relating to your past, present or future physical or mental health condition.

Further, by signing this authorization you acknowledge you have been provided a copy of and have read and understood Practice's HIPAA Privacy Notice containing a complete description of your rights, and the permitt4ed uses and disclosures, under HIPAA. While the Practice has reserved the right to change the terms of its Privacy Notices, copies of the Privacy Notice as amended would be available and can be received by sending a written request with return address to the center where you were seen. By signing below, you are acknowledging that you have received, reviewed, under and agree to the Notice of Privacy Practices, which describes the Practice's policies and procedures regarding the use and disclosure of any of your PHI created, received, or maintained by the Practice.

Acknowledged and agreed to by:

_____ _____

Patient/Guardian Signature Date

ZOOM
DIAGNOSTIC IMAGING

CONSENT FOR TREATMENT

I hereby direct Zoom Diagnostic Imaging, its agents, and employees to follow the instructions and directions of my referring physician. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to results of treatments, tests, or examinations.

Zoom Diagnostic Imaging does not accept any responsibility for money, articles of apparel, jewelry, dentures, eyeglasses, hearing aids, or any other valuables or belongings brought with the patient or patient's associates to Zoom Diagnostic Imaging.

The undersigned certifies that he/she has read and fully understands the above paragraphs; and further certifies that he/she received a copy thereof and is the patient or is legally authorized to act as a patient's agent to execute this document and accept its terms. I further recognize and accept that all physicians, who furnish services to the below named patient during this examination, are independent contractors and are not agents or employees of Zoom Diagnostic Imaging

_____ _____

Patient or Guardian Signature Date

_____

Patient Name