

Pink Door Imaging

BREAST & GYNECOLOGICAL IMAGING

PATIENT FINANCIAL RESPONSIBILITY

I authorize a direct payment to be made to Woman's Clinic, PLLC for all services.

Rendered directly from my insurance company _____.
YOUR INSURANCE NAME

I understand that I am responsible for all charges for services rendered that are not covered by my insurance day of visit. As a courtesy we will submit your claim to your insurance, however this is not a Guarantee of payment. Once a claim is processed and paid by your Insurance, there may, or May is not a balance due on your account. Your insurance is a contract between you, your employer, and the insurance company. We are NOT a party to that contract.

Not all services may be covered benefits in all contracts. Your employer selects and defines the services that are covered under your plan. You are responsible for non-covered charges.

We collect payments based on benefits received at the time of service. We make every effort to capture any refund that may be due to a patient in a timely manner, if you believe a refund is owed, please contact us and we will gladly review your account and issue a refund when due* ANY CREDITS \$25 and under will remain on account & applied for future appointments unless requested.

We will do our best to make every attempt to collect upfront fees for service, but always subject to the actual processing of the claim by your insurance.

Responsible Party Signature

Date