FINANCIAL POLICY STATEMENT

It is our policy to bill your insurance carrier as a courtesy to you, although you are ultimately responsible for the entire bill of our service, unless other arrangements have been made with Expert Breast Imaging, LLC, prior to your visit.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit the same to Expert Breast Imaging, LLC, if a balance is due.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, after such default and upon referral to a collection agency or attorney by Expert Breast Imaging, LLC, I will be responsible for all costs of collecting monies owed, including interest, court costs, collection agency fees, and attorney fees.

Your insurance company has developed maximum fee schedule for rehabilitation and other services. These schedules are internal to your insurance company and they may or may not cover all charges incurred during your treatment. The fee schedules often do not reflect standard charges in our area. Please be advised that you are responsible for the total charges or any difference remaining following payment by your insurance company. If you do not feel your insurance company has made adequate payment on your account, please contact them to discuss this matter.

Effective 10/10/2022 - We require all payments at the time of your visit. Payment for copays, coinsurance, deductibles and appointment balances are due at the time of service – unless other arrangements have been made with the business office.

Please note, a $50 “No Show” fee will be billed to your account if appointments are not canceled within 24 hours.

By signing below, you are agreeing to our Financial Policy and accept the responsibility of paying for your professional services rendered at Expert Breast Imaging, LLC.

I (print your name) ____________________________________, have read the above and fully understand the Financial Policy at Expert Breast Imaging, LLC, and am in agreement with the Financial Policy.

Signature of Patient, Guardian, or co-signer: __________________________________

Witness: ____

Date: __________________________