HOUMA MEDICAL
IMAGING CENTER

FINANCIAL POLICY

Patient Name_____ **Date of Birth**____/_____/____ **HMI Chart #**_____

Houma Medical Imaging is committed to making your experience at our center as pleasant as possible, even after you leave our facility. In the majority of cases as a convenience to you, We will submit your claim, and any secondary claims, to your insurance company under the benefit coverage you specify, including workers' compensation, auto insurance, and most personal injury. Your agreement with your insurance carrier is a private one, we can assist but are not solely responsible to research why an insurance carrier has not paid or why it paid less that anticipated.

Please understand that ultimately, the patient is responsible for payment of the account, including any balance not covered by insurance. At the time of your visit you are responsible for any known co-payment or deductible not satisfied at the time of your exam, as well as any non-covered services. In most cases, when your appointment is confirmed you will be provided with an **estimate** of any payment you need to bring with you to your appointment. In the event that your insurance company does not make payment within 45 days, the unpaid balance becomes your responsibility. Payment plans can be arranged by calling the Billing Office.

If you have questions or concerns about billing, please call the billing office at (337) 593-5420 (you may leave messages after business hours). Their business hours are 8:00 a.m. - 5:00 p.m. Central Standard Time.

Patients with insurance:
We will bill most insurance carriers for you if proper information has been provided to us. We will bill most secondary insurance companies for you. Co-payments and deductibles are due at the time of service. If an insurance carrier has not paid within 45 days of billing, your assistance may be required in contacting your insurance company and requesting payment. Pre-authorization may also be required by some insurance plans prior to your exam. Please check your policy or insurance card for this information.

Medicare Patients:
WVI is a Medicare approved facility and accepts assignment on all Medicare claims.
We will bill Medicare for you. We will also bill secondary insurance carriers for you. All co-payments, deductibles, and non-covered services are due at the time service is rendered.

Medicaid Patients:
All Medicaid patients must provide current participation information.

Workers Compensation:
If your injury is work-related, we will need the claim number and carrier name prior to your visit in order to properly bill the worker's compensation company.

Personal Injury Cases:
Please provide the insurance information, attorney's name and address, and/or your automobile insurance information

Non-covered Services:
Any care not covered by your existing insurance policy will require payment in full at the time services are rendered or upon notice of claim denial. In some cases, payment plans may be set up for the services rendered.

PLEASE CIRCLE ONE: I have met my insurance deductible for the calendar year	YES	NO	UNSURE

Medicare Patients: Signature on File *I request payment of authorized Medicare benefits be made either to me or on my behalf to Houma Medical Imaging, LLC for any services furnished to me by the listed provider. I authorize any holder of medical information about me to release to Centers for Medicare/Medicaid Services and its agents any information needed to determine these benefits for the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.*

Patients Name (please print) _____

Patients Signature _____ Patients Medicare Number_____

Assignment of Insurance Benefits *I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to Houma Medical Imaging, LLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment. I have read, understood and agreed to the above financial policy for payment of professional fees. The patient is ultimately responsible for all fees.*

Patients Signature_____ Date_____/_____/_____

Parent or Guardian Signature (if patient is a minor)_____ Date_____/_____/_____