



## FINANCIAL POLICY AND PAYMENT OPTIONS

Thank you for choosing Prescott Medical Imaging for your diagnostic medical imaging needs. We are committed to providing you with the best possible care and service.

**INSURANCE:** For your convenience we bill your insurance carrier(s) according to the information you provide to us at the time of registration. It is your responsibility to call your insurance to verify benefits and financial responsibility. Insurance is an agreement between you and your insurance company. We do not become involved in disputes between you and your insurance company regarding deductibles, co-payments, non-covered or denied services.

At the time of service we may collect your Co-Pay, Deductible or a Time-of-Service-Fee if the Co-Pay is unknown. We will submit your insurance claim for you as well as any claims to your secondary insurance. If your account remains unpaid after 60 days, please contact your insurance carrier for payment status. Ultimately, it is your responsibility to pay for your services. Any balances due after your claim is processed is also your responsibility. When making a payment you have the following options:

### PAYMENT OPTIONS:

- Cash
- Personal Check
- Money Order
- Credit Card: MasterCard, Visa, American Express, Discover
- Online payment through [www.pmixray.com](http://www.pmixray.com)

**PAYMENT PLANS:** Account balances must be paid in full within 30 days of receipt of balance due statements. Monthly payment plans are available for balances greater than \$100. Payment plans generally consist of 3-6 equal monthly payments. Please contact our Billing Service or make arrangements prior to service with our Authorization Specialist. We will work with you on an individual basis to resolve your account.

**FINANCIAL HARDSHIP DETERMINATION:** We are sensitive to the financial needs of each of our patients. Determination of financial hardship will take into consideration the current Federal Register Poverty Level Guidelines. An application is available through our Billing Service or by contacting Prescott Medical Imaging, or online.

## FINANCIAL POLICY AND PAYMENT OPTIONS (Continued)

**DISCOUNTS:** Prescott Medical Imaging offers “Prompt Pay” discounts under the following circumstances:

CATEGORY	NOTES	% DISCOUNT
Full payment at time of service (this does not include co-pays, deductibles, or time of service fees) Payment is made at time of service unless other arrangements are approved.	No Insurance Claim will be filed.	25% Discount
Payment in full of any self-pay balance within 30 days of billing of the patient portion.	Excludes Co-Pay and Deductibles	10% Discount

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance, as well as applicable co-payments and deductibles, are my responsibility.

I authorize my insurance benefits to be paid directly to Prescott Medical Imaging.

I authorize Prescott Medical Imaging and/or their Billing Service to release pertinent medical information to my insurance company when requested to facilitate payment of a claim.

\_\_\_\_\_ Date

\_\_\_\_\_ Patient Signature or Signature of Parent / Guardian

<b>PHONE NUMBERS:</b>	
Billing Office:	Phone: 928-778-6252
Authorization Specialist:	Phone: 928-771-7577 Fax: 928-441-1522

## FINANCIAL HARDSHIP APPLICATION FORM

Patient Name:		Date of Birth:
Address:		
City/State/Zip:		
Telephone:		

I am applying for a Financial Hardship Determination for the purpose of discounting my account balance for services and care provided to me. If a Medicare patient, I understand that Medicare regulations require you to bill for deductibles and co-pays and request that all or a portion of these Medicare charges be waived, if it is determined that such a payment would be a financial hardship for me. Determination will take into consideration the current Federal Register Poverty Guidelines.

I am supplying the following information so that you can make an accurate determination of my case. The monthly dollar amount provided is from all sources of income including Social Security benefits, pensions, annuities, dividends, employment, etc. Please include a copy of your previous year Federal Income Tax or W-2 Wage and Earning Statements to verify income.

Number of dependents residing with you (include yourself and spouse):	
Gross household earnings for the last tax year:	
Gross household earnings for the past three months:	

Current Monthly Income	Self	Spouse
Wage/Salary		
Social Security		
Pension/Retirement		
Interest Income		
Investments		
Other		
<b>TOTAL</b>		

Monthly living expenses: If income is above the 200% Poverty Guidelines, or if an increased discount is requested, an itemized listing of expenses needs to be presented.	
---	--

I certify that the above information is true and accurate to the best of my knowledge and will be used to evaluate my financial situation. If any information provided proves to be inaccurate, I understand that Prescott medical Imaging may re-evaluate my eligibility.

\_\_\_\_\_ \_\_\_\_\_  
*Patient Signature* *Date*

<b>OFFICE USE ONLY:</b>	Date _____	Waiver Approved <input type="checkbox"/>	Denied <input type="checkbox"/>
	Initial _____	Discount Approved <input type="checkbox"/>	Denied <input type="checkbox"/>
		Payment Plan Approved <input type="checkbox"/>	Denied <input type="checkbox"/>