

Mid-Michigan Breast MRI & Biopsy Center

Section 1: Financial Policy

Thank you for choosing Greater Flint MRI as your medical provider. We are committed to you and the success of your treatment. The following is a statement of our financial policy which we request that you read and initial before receiving service.

- Referrals- Greater Flint MRI must have all necessary claim forms, referrals, and insurance verification/authorization in order to complete your MRI today.
- Payment- For cash patients, a 60% deposit is required at the time of appointment. If you provide insurance information, our billing service will attempt to bill your carrier. All remaining balances **are the responsibility of the patient.**
- Patient Balances- Cash patients will receive a statement within 30 days for the balance of their procedure(s). **Please note: Unpaid accounts over 120 days will be sent to the Russell Collection Agency, Inc. for processing and payment.**

Please acknowledge your acceptance with your initials:

Section 2: Patient Medical Information Disclosure and Authorization for Medical Records Release

It is the policy of Greater Flint MRI to release medical information only to the patient, insurance provider(s), and referring and/or primary care physicians. All other requests for information disclosure will require a written or verbal request from the patient themselves. Please note: If the patient is a minor child, the parent or legal guardian are responsible for the patients medical information disclosure.

Furthermore, I authorize Greater Flint MRI to request medical information from my referring/primary care physician(s) that pertains to the reason(s) my MRI(s) was ordered. This information will be used for diagnosis and billing purposes.

Please acknowledge your acceptance with your initials:

Section 3: Privacy Practice

I acknowledge that I have been advised of the Notice of Privacy Practices information available at the front desk. Please mark your confirmation with your initials:

Please acknowledge your acceptance of the above stated Financial and Service Policies, Patient Medical Information Disclosure, Authorization for Medical Records Release, and your acceptance of the Greater Flint MRI Privacy Practices.

Signature

Date

Printed Name

Please note relationship if not patient

Witness