BERGEN
IMAGING CENTER, P.A.
WOMEN'S IMAGING SPECIALISTS OF ENGLEWOOD

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CHRISTOPHER L. PETTI, MD
ACCREDITED BY THE AMERICAN COLLEGE OF RADIOLOGY

Name: _____

Street Address: _____

City: _____

State: _____ Zip Code: _____ Social Security Number: _____

Home #: _____ Work#: _____

Cell #: _____ Date of Birth: _____

Email Address: _____

Referring Physician(s): _____

_____

Employer Name: _____

Employer Address: _____

City: _____

State: _____ Zip Code: _____ Employer Phone Number: _____

Race (Optional): _____

Nationality (Optional): _____

If you weren't referred to us by a physician, how did you hear about us?

Google □ Other □: _____

Signature: _____ Date: _____

BERGEN IMAGING CENTER FINANCIAL POLICY

It is the **patient's responsibility** to provide accurate and valid insurance information as well as obtain referrals, when required by your insurance plan. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance plan is a contract between you and your insurance company, we are not a party to that contract. **Knowing your insurance benefits is your responsibility.** Please contact your insurance company with any questions you may have regarding coverage.

Bergen Imaging Center will not waive, fail to collect or discount co-payments, coinsurance, deductible or other patient financial responsibility in accordance with **State and Federal Law**, as well as participating agreements with insurance carriers.

INSURANCE CARDS – must be presented at every visit. If a card is not presented, you cannot be seen until the card is presented and/or proof of active coverage is verified by this office.

REFERRALS – If your plan requires a referral from your primary care physician, it is your responsibility to obtain it prior to your appointment and have it with you at the time of your visit. **If you do not have a referral, you will be required to reschedule your appointment.**

MEDICARE – BIC participates with Medicare and we will submit your claim for the allowed amount. The patient will be responsible for the deductible and the 20% coinsurance, which can be billed to the secondary insurance carrier, if you have one. If you do not have secondary insurance, **we will collect the 20% coinsurance today.**

OUTSTANDING BALANCES – Balances over 90 days past due will be sent to a collection agency. Collection accounts will be subject to a **35% collection fee** which will be added to the past due balance. Patient will be responsible for all legal fees if the unpaid balance ends up in court.

RESCHEDULING, CANCELLING APPOINTMENTS AND NO SHOWS – No show, rescheduling or cancelling an appointment with less than 24 hours is subject to a **$50 fee**. This charge will not be covered by your insurance carrier and must be paid prior to any future appointment in this office.

$50 Administrative fee for patient checks returned by the bank.

HIPAA COMPLIANCY – I have been informed that a copy of Bergen/Digital Imaging Centers Notice of Privacy Practices is available to me upon request.

You are responsible for the timely payment of your account. If you have any billing questions, you can speak to someone in our on-site billing department. **WE ACCEPT CASH, CHECKS, DEBIT AND CREDIT CARDS.** Online payments can be made by visiting our website, **www.bergenimagingcenter.com**.

Thank you for reviewing and agreeing to our financial policy.

Patient Signature _____ Date _____

Print Patient Name _____