



FINANCIAL POLICY ACKNOWLEDGEMENT

Thank you for choosing Regional Medical Imaging as your medical provider. We are committed to you and the success of your treatment. Please understand that payment of your bills is considered part of your treatment. The following is a statement of our financial policy which we request that you read and sign prior to your exam.

Please give us all your insurance information necessary for us to bill your insurance carrier. We will only accept assignment of benefits with insurance plans with which we participate. Any remaining balances (such as co-pays and deductibles or non-covered services) are your responsibility.

- We are now able to authorize a credit card for future payment of your visit/testing. Your credit card is not charged until your insurance company notifies us of exactly what you owe.
- Full payment is expected at the time of service. Cash, Check, Visa, Master Card, and Discover are accepted.



- Any account with an account balance which has not had a payment made every month may be charged a billing fee.
- Any account over 120 days old without payment arrangements and monthly payment activity will be turned over to a collection agency.
- If you are not able to pay all of your patient responsibility on the date of service we have two payment plan options:
 - o Payment Plan 1 for patient balances less than \$500.00 - 20% down on date of service and six equal payments on the balance.
 - o Payment Plan 2 for patient balances greater than \$500.00 – 20% down on date of service and 12 equal payments on the balance.

If you would like to set up payment arrangements please contact our Billing Department at 810-244-3871 after you receive your first bill. Thank you for your understanding and for choosing us for your medical needs. Lack of patient and/or patient representative signature does not negate financial responsibility.

I have read and understand this financial policy as outlined.

Please print Name: _____

Signature/Patient/Responsible Party: _____ Date: _____

RMI Employee: _____

RMI-Scan signed document into patient’s file
Original-Give to patient