Financial Policy

Thank you for choosing Sun Radiology. We are committed to providing our patients the highest quality radiology services. This financial policy is an important part of your healthcare. Due to increased insurance company demands, we ask you to read and agree to the following:

We make every attempt to accept a wide range of insurance plans. For the patient's convenience, we file your radiology claim(s) with insurance plans with which we have an agreement, as long as valid insurance information is provided to us. However, all policies have different benefits, and we cannot know the specific details of each individual policy. It is the patient's responsibility to know their individual policy and to verify all benefits and coverage information prior to having any services rendered. Also, the patient is responsible for notifying us of any changes to his or her insurance plan or policy prior to his or her visit. If you are working with an attorney for a personal injury case, please be notified that you will be required to sign lien paperwork and this will be filed with the County Clerk's office. If you filed a worker's comp claim you must provide Sun Radiology this information before any services can be provided, failure to do so will result in you getting a bill for services.

Co-pays and Deductibles: Insurance policies are an agreement between the patient and his or her insurance company. Contracting with health insurance companies requires us to collect co-pays and deductibles. The patient must pay this amount prior to having services provided.

Additional Fees: If the patient does not have medical insurance or if Sun Radiology is not a contracted provider with his or her insurance carrier, all chargers will be due and payable at time of service. A $35.00 charge will be applied to all checks returned. There will also be a 3% credit card processing fee if you present with a credit card at the time of service. This fee is associated with the convenience of using your credit card and has created an additional expense for us to accept this form of payment which we have to in turn pass along to you. Additionally, a missed appointment for PET, CT, MRI and Nuclear Stress test will be a $250.00 charge. This fee is associated with the upfront cost to us having to pre-order your dose so we may perform your test. Other Radiology testing that the patient fails to cancel within 24 hours will result in the patient being charged a $50.00 no show fee. Regardless of the type of insurance you have these fee's will be accessed to your account if you fail to provide us 24-hour notice when cancelling or rescheduling your testing appointment.

Timely payment: If for any reason the patient incurs an account balance, we will mail a statement. Payment is due from the patient upon receipt of the first statement from our office. If the balance is not paid in full, Sun Radiology reserves the right to send the patients account to collections and an additional 35% collection fee will be added. Please be aware that any delinquent account balance may prohibit the patient from scheduling future appointments.

Payment plans: If for any reason you require a payment plan we require 1/3 of your estimated balance or $300 whichever balance is higher to be paid up front and then your monthly payments will be auto debited from the debit/credit card of your choice on the date that you delegate us to process your payment. If you fail to honor your scheduled payment the entire balance will be come due and expected to be paid within 10 days. Your card information will be stored in our secured credit card system that cannot be duplicated or used in any fraudulent manner. Sun Radiology adheres to all federal compliance regulations as part of our merchant agreement with the bank.

Your cooperation with this agreement will help us contribute to overall lowering the cost of medical care in our community.

I have read and understand the Sun Radiology financial policy. I authorize Sun Radiology to obtain and/or release medical information necessary for filing insurance claims on my behalf. I assign all benefits to which the patient or insured is entitled for my services provided to me to be paid directly to Sun Radiology. Should insurance payment be made directly to the insured, I agree to immediately pay these funds to Sun Radiology.

Patient Name (Please print)	Signature	Date

"The Leader in Quality Medical Imaging"

Phone: (623) 815-8200 Fax: (623) 815-8299

Release of Medical Information

*I, ______________________________ (Patient Name), hereby authorize Sun Radiology to send or discuss my test results and other health related information on my behalf with the following individuals:

1. Name: ______________________________ Relationship ________________________

   Phone: ________________________

2. Name: ______________________________ Relationship ________________________

   Phone: ________________________

3. Name: ______________________________ Relationship ________________________

   Phone: ________________________

*I authorize Sun Radiology to leave messages in detail about medical visits, lab and imaging results, and other health related information.

Voice message: Y / N   If yes, phone number: ______________________________

Text message: Y / N   If yes, cell phone number: ______________________________

Email: Y / N   If yes, email address: ______________________________

*If there are any updates or changes in this information, it is the patient's responsibility to notify Sun Radiology with new information.

Acknowledgement of our notice of private practices:

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Sun Radiology, P.C. Notice of Privacy Practices. By signing below, I am "only" giving acknowledgement that I have received or have had the opportunity to receive the Notice of our Privacy Practices. I acknowledge that I have received and read the Notice of Health Information Practices. I understand that my healthcare provider participates in Health Current, Arizona's health information exchange (HIE). I understand that my health information may be securely shared through the HIE unless I complete and return an Opt Out Form to my healthcare provider.

Signature: ______________________________ Date: ____________________

other side

HIPAA

"The Leader in Quality Medical Imaging"

PATIENT INFORMATION

Name:____________________ Date of Birth:__________ Age:____ Sex: ☐M ☐F

Address:_______________ City:________ State:____ Zip Code:________ SSN:________

Email Address:__________________ Phone: ____________ ☐Home ☐Work ☐Cell

EMERGENCY CONTACTS

Name:_________________ Relationship:____________ Phone:____________

RESPONSIBLE PARTY (If patient is under 18 years of age)

Name:_________________ Relationship to patient:__________ Age:___ Sex: ☐M ☐F

Phone:______________

Address:_____________ City:__________ State:____ Zip Code:_______

INSURANCE INFORMATION

Primary Insurance: ____________________ Member ID:____________________

Subscribers Name:____________ Relationship to Patient:_________ Subscriber's SSN:_________

Secondary Insurance:____________________ Member ID: ____________________

Subscribers Name:____________ Relationship to Patient: _________ Subscriber's SSN:_________

WORK RELATED INJURY (Only applicable if injury is related to work or auto accident)

Insurance Carrier Name:________________________ Phone:____________

Address:_________________ City:___________ State:____ Zip Code:_______

Date of Injury:__________ Claim Number:_______________

Employer at time of injury:___________________

INSURANCE AUTHORIZATION AND ASSIGNMENT (Please read and sign)

I attest that the information I have given here is correct and true to the best of my knowledge, I hereby assign benefits to be paid directly to the doctor, and authorize him/her to finish information regarding my illness to my insurance carrier. I understand that I am responsible for any amount not paid by my insurance. I authorize the clinic to obtain medication history electronically from any benefit administrator.

PATIENT/GUARDIAN SIGNATURE: ____________________________ DATE:___________