Reno Diagnostic Centers
When it has to be done right.

Financial Insurance Consent Form

Last updated: November 2, 2018

FINANCIAL POLICY

All professional services rendered are charged to the patient. The patient is responsible for all fees regardless of insurance coverage. Payment for services is due at time of registration.

INSURANCE AUTHORITY & ASSIGNMENT

I request that payment of authorized Medicare/Other Insurance Company benefits be made to Reno Diagnostic Centers for any services furnished me by that party who accepts assignment/physician. All regulations pertaining to Medicare assignment of benefits apply. Patients are responsible for all deductibles, co-insurance, and non-covered services, which is the charge determination of your insurance company.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or related Medicare claim/Other Insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment.

POLICY ON SMALL BALANCES

The amounts that we collect for your co-insurances and deductibles are generated from an estimate. If you are seeing multiple doctors, your deductibles or co-insurance amounts may change for each doctor, practice or specialist when your insurance processes your claims. As a result, an overpayment may occur. With the exception of governmental insurances, we will not be processing a refund for account balances that are *less than $5.00 (due to processing costs).* These small balance amounts will be adjusted off, but will be applied to your account should you come back in for a new service. Overpayment amounts that are greater than $5.00 will be returned.

_____ _____

Signature of patient or personal representative Date

_____ _____

Printed Name Relationship to Patient

*If you are signing as a personal representative, documentation of your legal right to do so must be provided.

Turn Over for additional Information

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Privacy Practices Consent Form

Last updated: April 5, 2018

Date: _____

ACKNOWLEDGMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

The complete RDC Notice of Privacy Practices is located at the reception desk and posted on the lobby wall. Should you wish to have a copy for your personal review, please notify a RDC staff member.
I have reviewed the Reno Diagnostic Centers Notice of Privacy Practices (HIPAA) and acknowledge that a hard copy has been made available to me upon my request.

_____ _____

Signature of patient or personal representative Date

_____ _____

Printed Name Relationship to Patient

*If you are signing as a personal representative, documentation of your legal right to do so must be provided.