



## Financial Policy

I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits. This includes any screening service or diagnostic testing ordered by the physician or physician's staff. If some payment is requested on the date of service, I understand this is only an estimate of the patient responsibility and that I will be responsible for any additional charges that are not covered by my insurance once the claim has been processed. If I do not have insurance, I understand that I am responsible for all financial charges. I further understand that any payment that is returned (such as a check that is returned due to non-sufficient funds) or has an invalid credit card number, I will be charged an additional fee.

I understand and agree that it is my responsibility and not the responsibility of the Physician or Imaging Center to know if my insurance will pay for my visit, screening service or diagnostic testing ordered by the physician or physician's staff.

I understand and agree it is my responsibility to know if my insurance has any Deductible, Co-payment, Co-insurance, Out-of-Network amount, Usual and Customary Limit, or any other type of benefit limitation for the services I receive.

If I have insurance, I agree to give Elizabeth Jekot MD Breast Imaging Center my current insurance information so that claims can be filed.

**Today's Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Patient Name:** \_\_\_\_\_  
(Last) (First)

**Patient's DOB** \_\_\_\_\_

**Patient Address:** \_\_\_\_\_  
\_\_\_\_\_

**Phone:** \_\_\_\_\_

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
**Date**

*For EJBIC Office Use Only:*

**Patient Account Number/MRN#** \_\_\_\_\_