Touchstone
MEDICAL IMAGING

Patient Registration Form and Billing Policy

Patient Name: _____ Date of Birth: _____

Mailing Address: _____ City/State/Zip: _____

Home Phone: _____ Cell Phone: _____

SSN: _____ Male: _____ Female: _____

Employer: _____ Work Phone: _____

Emergency Contact: _____ Emergency Contact Phone: _____

Insurance Carrier: _____ Policy/Member Number: _____

Patient Billing Policy

Payment Policy & Benefits Estimation

TO OUR PATIENTS: To help answer questions you might have, we have outlined our payment policies below. Please feel free to discuss these with us at any time, should you have additional questions.

Payment Policy: Accounts are payable after your insurance carrier has paid your claim, or within 30 days of your first statement. Self-pay patients will be asked to pay in full at the time of service. We accept all forms of payment. Please note: past due accounts will be turned over to a collection agency if the account is not paid in full within 90 days from the date of your first statement. You may make payments online (www.touchstoneimaging.com). If you require financial assistance or a payment plan, please call 1-877-275-9077. Any payments received by Touchstone may be applied to the oldest date of service for which you have an outstanding balance due to Touchstone. Patients will be financially responsible for any return check fees that Touchstone incurs.

Benefits Estimation: If we are filing with your insurance, please keep in mind we make every effort to collect only the portion you owe at the time of service. However, this is an estimate and you may have a remaining portion to pay as a copay, co-insurance, or deductible. Your insurance plan will send you an "Explanation of Benefits" (EOB) which explains how your claim was processed. You will receive a statement of any balance you owe after we receive payment from your insurance(s). As a service to you, we endeavor to provide the most accurate information regarding network participation (i.e. in-network vs. out-of-network) and cost to you as our patient. However, these are estimations based on information available from your insurance carrier and subject to change given your insurance's final deliberation of this claim. It is your responsibility to verify the network participation of our facilities with your insurance carrier as well as the patient benefits you receive at our facilities. Should your insurance deny your claim for reasons beyond our control, you assume responsibility for payment for the claim. I have read and understand the above-referenced policy and benefits estimation. Initial: _____

Assignment of Benefits & Authorization to Pay

Assignment of Benefits: I, the undersigned, hereby authorize Touchstone Medical Imaging to release any medical or other information necessary to process my claims for services rendered to me or my dependent. Initial: _____

Authorization to Pay: I, the undersigned, hereby authorize payment of medical benefits to the physician or supplier for services rendered to me or my dependent in connection with imaging studies performed by Touchstone Medical Imaging. Initial: _____

Collection Procedures and the TCPA Act:

I authorize Touchstone Medical Imaging, its assignees, and third party collection agents to utilize all contact information I have provided to communicate with me. This includes, but is not limited to, home telephone, cellular telephone, employment telephone, and email/text communications. I hereby grant permission and consent to Touchstone Medical Imaging, its assignees, and third party collection agents to place calls to my home telephone, cellular telephone, and employment telephone; leave messages (whether voice or text); and utilize pre-recorded/artificial voice messages and/or automatic dialing devices in connection with any communication to me. Information will only be supplied to Touchstone Medical assignees and third-party collection in order to collect on outstanding balances. Initial: _____

By signing below, I hereby acknowledge that I have read, understand, and consent to all policies set forth herein.

Date: _____ Patient/Guardian Signature: _____