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: 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 at (www.touchstoneimaging.com). If you require financial assistance or a payment plan, please call 1-877-275-9077. Touchstone may apply payments received to any outstanding balance. Patients will be financial responsible for any return check fee's 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 only 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.

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.

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.

COMMUNICATIONS CONSENT:

I authorize Touchstone Medical Imaging, its representatives, agents, and third-party vendors, to contact me using live agents, voicemails, pre-recorded messaging, auto-dialed calls, emails, and/or text messaging to any phone number (including wireless numbers) or email address provided or associated with me or my personal representative in connection with any matter relating to my treatment, payment, or account, including but not limited to scheduling, appointment reminders, billing, payment, collections, patient surveys, and information about products or services that may be of interest to me. I authorize Touchstone Medical Imaging, its representative, agents, and third-party vendors to send me unencrypted messages using these means of communication. Providing this consent is not a condition of receiving medical treatment or services. I understand that I can also decline to receive further communications by following opt-out instructions as provided.

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

Date: _____ Patient/Guardian Signature: _____