WASHINGTON OPEN MRI, INC.
FINANCIAL POLICY

Overview - This is our financial policy and we require you to read and sign it prior to any treatment. All patients must complete our information and insurance forms and give us all necessary referral slips and authorizations before having their MRI study. Full payment is due at the time of service. We accept cash, checks or VISA/MasterCard/American Express/Discover. With prior credit approval we also offer an extended payment plan.

Regarding Insurance – You are responsible for the payment of our fees if your insurance company does not pay. We cannot bill your insurance company unless you give us your insurance information and an original claim form. Your policy is a contract between you and your insurance company. We are not a party to that contract. In the event that we do accept assignment of benefits under your health insurance plan, we require that you be pre-approved for extended payment plan or else provide a credit card to us with authorization to bill the card for the balance of our fees. If your insurance company has not paid your account in full within 45 days, the balance will automatically be transferred to your credit card or to the extended payment plan. Please be aware that some and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare program and/or other medical insurance. Insurance information must be furnished in writing on the forms provided at the time of service. Any insurance coverage submitted after the MRI study is performed will not be billed by Washington Open MRI, Inc.

Regarding Insurance Plans - All co-pays and deductibles must be paid prior to treatment. In the event that your insurance coverage changes to a plan where we are not a participating provider, refer to above paragraph. If your study has been ordered because of possible injury suffered in an auto accident, auto insurance is considered primary and health insurance is secondary. It will be billed and payment will be accepted in the same order. Since Medicaid/ Medical Assistance is not accepted nor billed by Washington Open MRI, Inc., I agree to pay any balance that will not be billed to the Medicaid/Medical Assistance programs.

Usual and Customary Rates – Washington Open MRI, Inc. is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Additional Charges – All collection and legal services utilized in order to collect a balance remaining on your account will be payable by you. In addition we reserve the right to charge you for the following services:

- A $5.00 rebilling charge for each additional billing statement
- A $5.00 charge for three or more requests to fax written results to other than the referring doctor.
- A $5.00 charge for additional copies of reports and/or itemized bills.
- A $5.00 rebilling charge, for two or more claims resubmitted to your insurance company
- A $75.00 charge for the printing of each additional set of films.

Missed Appointments - Unless canceled at least 24 hours in advance, our policy is to charge for missed appointments at the full rate of an MRI study. Please help us serve you better by keeping all scheduled appointments.

Authorization and Assignment - I authorize Washington Open MRI, Inc. to apply for insurance benefits on my behalf. I authorize all insurance payments to be made directly to Washington Open, MRI, Inc. I authorize Washington Open MRI, Inc. to release to my referring physician and my insurance plan(s) all necessary information and/or medical information regarding all MRI studies performed on me. I authorize you to use a copy of this form in place of the original. The authorization to release medical information may be revoked in writing by me at any time.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read this Financial Policy and agree to be bound by the terms and conditions of this Financial Policy.

_____	_____	_____
Signature of Patient or Responsible Party	(Please print your name)	Date
_____	_____	_____
Signature of Co-Responsible Party	(Please print your name)	Date