Advanced Diagnostics, Inc.
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Office (803)419-4235 Fax (803)419-4236

Financial Policy

Thank you for choosing Advanced Diagnostics, Inc. for your health care needs. Our patient financial policy has been developed to assist in answering any questions regarding patient and insurance responsibility for services rendered that you may have. Please read our Financial Policy below and if you have any questions, do not hesitate to discuss them with our staff. The original will be maintained in your file and a copy may be provided to you upon your request.

1. **PROOF OF INSURANCE:** All patients must complete our patient information form and provide copies of insurance card(s) and a picture ID. Advanced Diagnostics, Inc. participates with a variety of insurance plans. Our staff can verify if we participate with your specific insurance plan. If we do not participate with your specific insurance plan, payment in full is expected at each time of service unless other arrangements are made in advance.

2. **UPDATED CHANGE OF INFORMATION & COVERAGE:** We will ask you to update your information yearly or whenever you have a change in address, employment, insurance, etc. However, it is your responsibility to make us aware of these changes. Failure to provide correct updated information, may result in your full financial responsibility.

3. **CO-PAYMENTS, DEDUCTIBLES & CO-INSURANCE:** All co-payments, deductibles & co-insurance must be paid at the time of service unless other arrangements are made in advance. Payment of your copayments, deductibles & co-insurance is part of the contract agreement with your insurance plan. You may receive a bill for the remaining amount that is due if it exceeds the minimum amount collected.

4. **AUTHORIZATIONS:** Obtaining a prior authorization for services is not a guarantee of payment of benefits. A prior authorization means that the information given at the time that the authorization is requested meets the medical necessity for the services; not a guarantee of payment. Your insurance plan will confirm to you that even though the services may be authorized; the services may not be covered under your plan and a decision for payment will not be rendered until a claim is submitted.

5. **CLAIMS SUBMISSION:** We will submit your claims and assist you in any way to help get your claims paid. Your insurance plan may request information directly from you. Your failure to timely comply to your insurance plan's request may result in a denial of your claim. Should a claim be denied for this reason, you will be held financially responsible. Your insurance benefit is a contract between you and your insurance plan. **Your exam may also be submitted to a third party physician for the interpretation. The third party physician will submit your claim to your insurance plan. It is your responsibility to make any additional payments, not covered by your insurance plan, directly to the interpreting physician's office.**

6. **SELF-PAY:** If you do not have valid health care coverage, you will be considered as self-pay. Payment in full, is due at the time of service.

9. **NON-PAYMENT:** If your account is over 60 days past due, you will receive a statement indicating that you have 30 days to pay your account in full. If you are unable to pay your balance in full, you must contact our office to discuss other arrangements. Please be aware that if a balance remains unpaid, your account may be turned over to a collection agency for collection.

10. **RETURNED CHECKS:** A returned check fee of $30 will be added to your account for every check returned by your bank for insufficient funds, stopped payment or closed accounts. After the second occurrence, only cash, money orders, cashier check's or credit card payments will be accepted.

Knowing your insurance benefits is your responsibility. Please contact your insurance plan with questions regarding coverage

This is an agreement between Advanced Diagnostics, Inc. and the patient/responsible party signed below. By signing, you acknowledge receipt of this agreement and you are agreeing to abide by the financial policy above and pay for all services that are rendered.

_____ _____

Signature of Patient or Responsible Party Date