

SWI DIAGNOSTICS
GENERAL AND VASCULAR ULTRASOUND SERVICES

Welcome to the Office of SWI Diagnostics
PATIENT INFORMATION RECORD

TODAY'S DATE: _____

Patient's Name: _____
Last First MI

Address: _____
Street

_____ City State Zip Code

Referring Physician _____ Phone

Home Phone(____) _____ Work(____) _____ Cellular(____) _____
(Please circle best number to reach you during the day)

E-Mail Address: _____ Sex: M F

Date of Birth: ____/____/____ Age: _____ Social Security #: ____/____/____

Employer: _____

Occupation: _____

How did you learn about SWI Diagnostics? Doctor / Former Patient / Friend / Internet / Yellow Pages / Other?

Name: _____

Emergency Information

Person to Call: _____ Relationship: _____

Phone: (____) _____

Payment is required at the time of service. Most insurance companies cover SWI, Diagnostics services as an outof-network provider. We will assist you in obtaining reimbursement by providing you with an itemized "detailed" receipt, which you can send, as is, to your insurance company for reimbursement. Your signature below indicates you are financially responsible for all charges incurred, that you understand unpaid balances over 60 days will be assessed 1% compounded monthly interest unless other arrangements have been made, and that outstanding balances over 90 days will be processed by a Collection Agency.

Signature of Patient or Legal Guardian: _____

PLEASE CHECK PAYMENT METHOD:

Cash

Check

Mastercard / Visa

Credit Card Number: _____ Exp. Date: _____

Security Code: _____

(Shown on reverse side of card in the signature label)

Credit Card Authorization Signature: _____

PLEASE PRESENT YOUR INSURANCE CARDS TO THE RECEPTIONIST SO WE MAY HELP YOU
WITH YOUR INSURANCE REIMBURSEMENT.

GENERAL FINANCIAL POLICY

Thank you for choosing us to perform your ultrasound. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

Proof of insurance. All patients must complete our patient information form before having their study. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

Claims submission. We will do everything possible to assist you in obtaining reimbursement from your insurance company. Your insurance company may need you to supply certain information directly. An itemized "detailed" will be given to you after each visit with codes and information regarding your visit that you may mail directly to your insurance carrier for reimbursement directly to you. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this facility. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care.

Missed/ Late appointments. Our policy is to charge for missed appointments not canceled within at least one hour before your scheduled appointment time. We try not to have you waiting please provide us with the same courtesy. If you are more than 15 minutes late your appointment will be cancelled. Please help us to serve you better by keeping your regularly scheduled appointment.

I acknowledge having read and understand the above General Financial Policy

I authorize SWI, Diagnostics to release any information required to process my claim.

Print Patient Name

Date

Is the address listed on the previous page your billing address? _____

If not, please not billing address: _____