CNMRI Payment Policy

Thank you for choosing CNMRI. 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 developed 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.

1. 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.

2. Co-payments. All co-payments 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 from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some of the services you receive could be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must sign our patient information/billing form before seeing the doctor. 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.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. 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.

6. 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 60 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 60 days past due, you will be sent to the collection agency on the first of the month following your 60 day notice. Partial payments will not be accepted unless otherwise negotiated and you may be discharged from the practice.

8. Missed appointments. Our policy is to charge a fee for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Future appointments will not be made until the missed appointment fee is paid in full. Please help us to serve you better by keeping your regularly scheduled appointment.

9. Form Completion. CNMRI offers completion of forms as an added service to patients. It is our policy to collect a fee for these forms since it does require staff time and supplies to complete them accurately. If a form is requested to be completed there will be a prepaid fee of $10 per page up to $50. Any form submitted should be given FIVE working days for completion. If forms need to be processed more urgently there will be an additional $10 expedited form completion fee. The prepayment is expected at the time the form is presented. If the form is received by fax or mail, you will be contacted and the fee will be requested. For convenience these fees can be paid online through our patient portal. The form will not be completed until the fee has been received.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.
Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party **Date**