North Fork Radiology, P.C.

1333 Roanoke Avenue
Riverhead, NY 11901
631-727-2755

Insurance Waiver

North Fork Radiology has advised me that my insurance (Medicare/ Medicaid and/or Commercial carriers) may not cover the procedure(s) that were performed today (_____). Knowing this I have instructed North Fork Radiology to proceed with services. If my insurance (_____) decides to reduce and/or deny the services, I agree to pay North Fork Radiology fees in full.

Insurance Payment Order

Medicare:

If applicable, I request that payment of authorized Medicare benefits be made on my behalf to North Fork Radiology for services provided to me by North Fork Radiology. In the event I receive payment from Medicare for services rendered by North Fork Radiology, I agree to reimburse North Fork Radiology.

Indemnity Insurance:

If applicable, I authorize (_____) to pay North Fork Radiology directly for benefits due to me as outlined by the indemnity terms of my policy. My policy was in full force and effect at the time that these services were rendered. Payment as herein directed, in whole or part, shall be considered the same as if paid, by your company, directly to me.

Release of Medical Information:

I authorize any holder of medical information about me to be released to the Health Care Financing Administration, its agents, any applicable insurance company, referring physician and/or medical physician or specialist in order to determine these benefits or the benefits payable for related services.

Patient Responsibility and the Collection Process:

Please be advised that if you have a balance due and fail to pay this balance in a timely fashion and your account is turned over to collection, there will be a 30% surcharge in addition to the actual balance owed.

Patient's Signature: _____ Date _____