



Pueblo Radiology Medical Group

## For Non-Medicare Patients of Pueblo Radiology

PATIENTS WITH INSURANCE: (Please present your card so we may make a copy).

I hereby authorize Pueblo Radiology Medical Group, Inc., to furnish my insurance company with all information which said insurance may request concerning my present illness or injury. I hereby authorize payment directly to Pueblo Radiology Medical Group, Inc., and I understand that I am financially responsible for all applicable charges regardless of a third party payor. Because there are so many forms of insurance coverage, it is my responsibility as the patient to be fully informed as to what is included or excluded in my policy, as well as the requirements and limitations. For example, I will be responsible for personally paying the Pueblo Radiology bill as it applies to:

- any deductibles
- any insurance claim denial
- my lack of eligibility with the insurance
- the lack of prior authorization provided by me or my physician

As patient or legal guardian of patient, I agree to pay for all services rendered within 60 days of service in accordance with the financial policy of this office. In the event legal action should become necessary, I agree to be responsible for and pay all reasonable attorney and court fees incurred. I understand that this office bills insurance as a courtesy and that payment of the charges for these services is my responsibility.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Please Print Name**

If you would like a copy of this form, please notify our office staff. Thank you.

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