Acknowledgment of Financial Responsibility Form

Date of Service: _____

Services Rendered (CPT code and description):
_____
_____
_____

I authorize the release of any information necessary to process an insurance claim. I understand that I am financially responsible for any balance due. Note: Some insurance carrier may require pre-certification and/or authorization for radiology imaging services. I acknowledge that if authorization is not approved prior to services being rendered. I will be financially responsible for all charges incurred during my visit.

Your signature on this form acknowledges that you agree to bear full financial responsibility for all services provided as listed below if:

1. The services are not covered under your Insurance carriers benefit plan; or

2. The services have not been otherwise approved for payment by your insurance carrier.

Print Name of patient/guarantor: _____

Signature of patient/guarantor: _____ Date: __ /__ /_____

Relationship to patient, if guarantor: _____

Provider: University Diagnostics, Inc. D.B.A. Orange County Diagnostics

National Provider Identifier: 1306835038

Signature of Representative: _____ Date: __ /__ /_____