



**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: \_\_/\_\_/\_\_\_\_\_

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