ORLANDO HEALTH® | Imaging Centers

LINE UP PATIENT I.D. LABEL HERE

ABOUT FINANCIAL ARRANGEMENTS AND MEDICAL INSURANCE
Estimate Of Benefits and Patient Responsibility
ALTAMONTE / DOWNTOWN ORLANDO / SPRING LAKE / OCOEE

We are committed to providing you with the best possible care. If you have medical insurance we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for services is due at the time services are rendered unless other payment arrangements have been approved in advance by our staff. **We will collect the fees estimated to be due from patient in advance of or at the time of service. This amount may change once your Explanation of Benefits (EOB) is received from your insurance carrier. We accept cash, checks, American Express, Discover, MasterCard and Visa.**

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. By signing below, you agree that you understand the following:

1. Your insurance is a contract between you and your employer, and your insurance company. ***WE ARE NOT A PARTY TO THAT CONTRACT***
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of "U.C.R.". "U.C.R." is defined as Usual, Customary, and Reasonable fees for this region. Thus, our fees are considered Usual, Customary, and Reasonable by most companies. However, this statement does not apply to companies that reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.
3. Not all services are a covered benefit in all insurance contracts. Some insurance companies arbitrarily select certain services they will not cover.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE do not hesitate to ask us. We are here to help you.

I understand and agree (regardless of my insurance status) that I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information in this document. I hereby individually obligate myself to pay and unconditionally guarantee payment to OHRI, LLC of patient's co-payments, deductibles, and non-covered charges, in accordance with the regular rates and terms of OHRI, LLC or such other rates and terms as are applicable to the patient's account by contract or regulation. Should any portion of the patient's account be referred to an attorney for collection, I agree to pay all expenses of collection, including reasonable attorney's fees, whether or not suit is filed.

Returned checks and balances older than 30 days may be subject to additional collections fees and interest charges of 1.5% per month. Charges may also be made for broken appointments and appointments canceled with less than 24 hours advance notice.

Patient OR Patient's Representative (Relationship)	Date	Time
Parent / Guardian Signature (If minor)	Date	Time

Orlando Health Imaging Centers are owned and operated by OHRI, LLC, a Florida limited liability company.

INTERPRETER ONLY	PATIENT ASSISTANCE PROVIDED
Interpreter Name: _____ Agency & I.D.#: _____ Team Member Name & I.D.#: _____ ❑ Video Remote ❑ Tel ❑ In person Language: _____	❑ Reader for Visually Impaired Name: _____