Transmed Inc.
The Ultrasound Professionals

PATIENT PAYMENT & FINANCIAL AGREEMENT

Transmed, Inc. is committed to providing you with the best possible medical care. *The patient or parent signing the payment & financial agreement is established as the account holder for the family.* The account holder is not necessarily the insurance subscriber. The account holder accepts full responsibility for payment of all charges.

FEES & PAYMENTS: As a courtesy to patients, **Transmed, Inc.** is pleased to assist in the submission of medical insurance claims to insurance companies for payment. I understand that it is my responsibility to confirm that the provider, **Transmed, Inc.** is a participating provider under my policy. Further, I understand that my insurance company may not cover 100% of my bills for services provided, and I will be responsible for the payment of any remaining balance due.

I understand that it is my responsibility to provide **Transmed, Inc.** with appropriate and current insurance information, and to notify Transmed, Inc. immediately upon any change in my insurance coverage to ensure efficient claims billing and payment. In the event that I fail to provide all necessary and current insurance information, I understand that my insurance company(ies) may deny payment of claims relating in services rendered to me, and I understand that I may be fully responsible for my entire account balance.

I understand that I will be responsible for paying co-payments, deductible, and any fees relating to services rendered that are not fully (or at all) covered by my insurance company(ies).

I understand that if my insurance requires a co-pay, the co-pay is required at the time of service.

I understand that if I am uninsured, I will be responsible for paying any fees relating to services rendered.

INSURANCE ESTIMATES: I understand that the insurance estimate may differ from what my insurance carrier ultimately pays and that I am responsible for any amounts not paid by my insurance for any reason. I understand that it is my responsibility to confirm which treatments or procedures are covered by my insurance, including, but not limited to, any applicable exclusions or deductibles or annual or lifetime maximums.

COLLECTIONS: In the event of failure to pay for medical services rendered, I understand that I may be referred to a collections agency for non-payment of fees due for services rendered by **Transmed, Inc.**

FINANCE CHARGES: I understand that all account balances over 30 days will incur an interest charge at 1.25%.

RETURNED CHECK FEE: I understand that in the event that my check is returned for insufficient funds, I agree to provide cash, money order or certified check for the full amount of payment owed, in addition to a $30.00 returned check charge.

We encourage you to discuss any financial concerns that you may have so that we may assist you in the effective management of your account.

I, THE UNDERSIGNED HAVE READ AND UNDERSTAND THIS INSURANCE INFORMATION & PAYMENT AGREEMENT. I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL, OR OTHER INFORMATION NECESSARY TO PROCESS THE INSURANCE CLAIMS, OR OTHERWISE OBTAIN PAYMENT, AND ACCEPT FULL RESPONSIBILITY FOR PAYMENT OF ANY FEE(S) NOT COVERED BY INSURANCE.

A photocopy of this agreement is as effective and valid as the original.

_____ _____

Patient Signature (or Parent or Guardian, if applicable) Date

_____ _____

Print Patient Name Print Name of Parent or Guardian (if applicable)

7001 S Lyncrest Pl ● Suite 101 ● Sioux Falls, SD 57108 ● (605) 274-2525 ● Fax(605) 274-0620