PET/CT IMAGING
OF BERKELEY
2855 Telegraph Ave., Suite 100, Berkeley, CA 94705
AMERICAN COLLEGE OF RADIOLOGY ACCREDITED PET AND CT FACILITY

Thank you for choosing PET/CT Imaging of Berkeley for your diagnostic imaging needs. We are honored by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibility

- The patient is ultimately responsible for the payment of his/her treatment and care.
- The patient is required to provide us with the most correct and updated information about their insurance and the patient will be responsible for and charges incurred if the information provided is not correct or updated.
- Patients are responsible for the payment of co-pays, co-insurance, deductibles and all other procedures or treatments not covered by their insurance plan. If any payment is due at the time of service, we accept cash, check, and most major credit cards. Any payments received by PET/CT Imaging of Berkeley will be applied to any unpaid bill(s) for which the patient is liable. Any and all balances assigned as patient responsibility may be subject to collection efforts after 90 days, as well as credit reporting.
- Patients may incur, and are responsible for the payment of additional charges. These charges may include (but are not limited to)
    - Charge for returned checks.
    - Charge for missed appointments without 24-hours advance notice.
    - Charge for the copying and distribution of additional patient medical records.
    - Any costs associated with collection of patient balances.
- By my signature below, I acknowledge and understand that it is ultimately my responsibility and obligation to be aware of my insurance's requirements, coverages, deductibles and payments.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form:

Patient Signature:_____ Date:_____

Patient Authorization for Release of Medical Records

- By my signature below, I hereby authorize PET/CT Imaging of Berkeley to release medical and other information acquired in the course of my examination to the necessary insurance companies, third-party payors, and/or other physician or healthcare entities required to participate in my care.
- By my signature below, I authorize PET/CT Imaging of Berkeley personnel to communicate by mail, answering machine message, voicemail, and/or email according to the information I have provided in my patient registration information.

I have read, understand, and agree to the provisions of this Patient Authorization Release of Medical Records Form:

Signature of Patient :_____ Date:_____