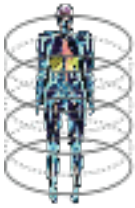

HDC
HOLLYWOOD DIAGNOSTICS CENTER

4224 Hollywood Blvd. Hollywood, FL 33021
Ph 954.966.3600 Fx 954.967.1962

FINANCIAL RESPONSIBILITY POLICY

CO-PAYMENTS: Due at each visit prior to any diagnostic procedure(s) being performed.

MEDICARE: Hollywood Diagnostics Center participates and accepts assignment with Medicare Part B. Please provide your Medicare ID card during the check-in process. Deductibles that are not yet satisfied are your responsibility. Patients without secondary insurance are responsible for the 20% co-insurance.

HMO INSURANCES: If you participate in a HMO, Hollywood Diagnostics Center will submit charges to your insurer for any studies performed. Co-payments will be collected before services are rendered. Deductibles that are not yet met are your responsibility and those amounts will also be collected before services are rendered. Please check with your healthcare provider's office prior to your visit to ensure that Hollywood Diagnostics Center has received the appropriate authorization and referral for each study being done. Please be advised that authorization from your insurance provider is not a guarantee of payment. Any charges your insurance provider does not pay will ultimately be your financial responsibility.

COMMERCIAL INSURANCES: Although we participate and accept assignment with most major third-party insurers, we perceive your insurance coverage as a contract between the insurance company and you. Deductibles that are not yet satisfied are your responsibility. Co-payments will be collected prior to any studies being performed.

SELF PAY: Patients without insurance coverage are expected to pay in full at the time services are rendered. We accept cash, checks, and all major credit cards.

PATIENT BALANCES: Payment is due upon receipt of statement. Balances not paid within 30 days of initial billing are subject to collections. Should your account be turned over to collections, you will be responsible for all associated costs and/or attorney's fees.

I have read the above Financial Responsibility Policy and understand that, regardless of any insurance coverage I may have, I am fully responsible for payment of my account. I hereby attest that I have provided accurate personal and insurance information to the best of my knowledge to ensure complete and timely payment.

_____

PATIENT NAME (Please print)

_____

SIGNATURE OF PATIENT/PARENT/LEGAL GUARDIAN

_____

DATE