MRN: _____

Date of Service: _____

Revere Health
Your health above all else

» Agreement of Financial Responsibility

Patient Name: _____ Date: _____

Insurance Carrier: _____ ID Number: _____

SECTION 1 (PROVIDER COMPLETES THIS SECTION)

Description of non-covered service(s), for which the patient agrees to accept financial responsibility:

Service Description:	Reason Insurer May Not Pay:	Estimated Cost:

Revere Health Imaging, certifies that this office has an established policy for billing all patients, for services not covered by a third party. The patient has been advised prior to services being rendered the specific non-covered service(s) to be provided and the expected cost.

Provider Representative Signature:	Date:

SECTION 2 (PATIENT OF RESPONSIBLE PARTY COMPLETES THIS SECTION)

I am the patient or responsible party. I understand my health plan may not pay for the services described in Section 1. I have been told what the expected cost will be. I have been informed and have signed this agreement before receiving the described services. I have been told why I may be billed and agree to pay for service as described in Section 1.

Signing below means that you have received and understand this notice. You will also receive a copy.

Patient/Responsible Party Signature:	Date: