Patient Consent & Financial Policy

Thank you for choosing SMIL/SDI as your Imaging Provider. We are committed to providing you with quality and affordable healthcare. **Please read below our patient consent to treat and financial policy, ask us any questions that you may have, and sign below.** A copy will be provided to you upon request.

- I am consenting to treatment and services ordered by my Healthcare Provider to be performed by SMIL/SDI.
- I authorize the company as holders of medical information to release to my insurance carrier or its intermediaries any information needed for this or future related claim(s).
- I further request payment to be made to the company and authorize the company to submit claims on my behalf for any bills or services furnished me by the companies during the next 12 month period.
- I understand that I am financially responsible to the company for any balance not covered under my insurance plan (e.g. the services were not included in my plan, were not deemed medically necessary, were considered investigational by my carrier, coverage is not effective at the time of service, were not pre-authorized, or my insurance is out of network)
- I understand I am responsible for confirming and understanding my insurance carrier's coverage limitations and policies, including my obligation for deductibles, co-insurance, and co-payments.
- I understand that all payments are due at the time of service, including self-pay fees, deductibles, co-insurance, and co-payments unless prior arrangements have been made with the company's Patient Financial Services department.
- I understand that any payment made at the time of service is the company's best estimate; however, the actual benefit will be determined by my insurance carrier and the specific terms of my benefit plan, the amount of my deductible I have satisfied, and certain payment policies my insurance company may apply in paying my claim.
- I understand that payments may also differ from the estimate if it is necessary to perform a different procedure, additional procedures and/or imaging views are needed or contrast needs change. Should there be a difference in the actual benefit calculation compared with the company's estimate, I will be responsible for any underpayment. Any overpayment will be refunded to me by the company.
- I understand that I may be asked to furnish a photo ID and my current/valid insurance card or complete insurance information to staff at each visit in order to process the claim.
- I understand that any returned checks are subject to further collections and/or fees.
- I understand that the company accepts attorney liens on all third party billing over $200. The attorney information I fill out at the time of service does not constitute a lien. This will be my responsibility to follow up and verify the lien has been signed by my attorney. If there is no signed lien, the account is subject to an outside collections agency unless I make other payment arrangements with the Patient Financial Services department.
- I agree to pay all cost of collection if my account is delinquent, including all collection fees, attorney fees and other costs incurred in the effort to collect on my account.
- We may also use or disclose your PHI to support medical research that we conduct, or to support our business analytics. To do this, we will use standard de-identification practices to de-identify your PHI before it is disclosed.
- SMIL does not request advanced directives, however, if you would like to place one on file please reach out to administration at info@esmil.com

By signing below I acknowledge that I have read and understood the financial patient responsibility policy and consent for the treatment provided by SMIL/SDI and agree to abide by its guidelines:

Signature: _____ Date: _____

Revised 12/07/22