SANTA BARBARA women's IMAGING CENTER

Patient Acknowledgement of Financial Responsibility

Please be advised even though we may be listed as a provider with your insurance company, it does not imply that payment is guaranteed or that your insurance company will pay in full. You may be responsible for your deductible, co-payment or other out-of-pocket expense as described by your insurance carrier. In addition, your insurance company may take the position that the service you are scheduled for today (3D mammography or "Tomosynthesis") is either experimental or not medically necessary and may therefore deny payment.

Our billing agent is **Zotec Partners**, with a main office in Indianapolis and a local office in Orange County. Our practice is contracted with insurances under the name **California Managed Imaging Medical Group, Inc.** Please remember to associate your service in our office with these entities.

You will receive a bill from our office for any deductible or co-payment amounts owed, as described by your insurance company. If you have paid moneys today, please understand that these are **estimated amounts only** and it is very likely that you will owe additional money following insurance processing. Initial here to acknowledge: _____

Any questions as to how your insurance company pays for today's service must be directed to your insurance company.

Please sign below to indicate you have read, understand and accept this responsibility.

Thank you.

_____
Patient Signature
[Patient Name] MR# [MRN]
Date:[dos]

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