Patient Registration

Riverwoods Advanced Diagnostic Imaging and Cardiovascular Centers

280 West River Park Drive, Provo, Utah 84604
www.RiverwoodsImaging.com
Phones (801) 229-1009 or (801) 229-2002 * Fax (801) 229-1003

PATIENT INFORMATION												
Patient Name:	Last:		First:		Middle:		Maiden:					
Home Address:			City:		State:		Zip:					
Phone Numbers:	Home:		Work:		Mobile:							
Personal Information:	DOB:		Sex:	❑ Male ❑ Female	SSN:		Marital Status:	❑ S ❑ M ❑ D ❑ W				
Employment:	❑FT ❑PT ❑RET ❑N/A		Student Status:	❑FT ❑PT ❑N/A								
Emergency Contact Name:			Phone Number:		Relationship:							
Referring Physician Name:			Description of Symptoms:									

PRIMARY INSURANCE INFORMATION (PLEASE HAVE INSURANCE CARD ON HAND FOR COPIES)									
Primary Insurance Company Name:									
Policy Number:		Plan Name/Group Number:							
Policy Holder's Name:									
Policy Holder's Address:		City:		State:		Zip:			
Phone Numbers:	Home:		Work:		Mobile:				
Policy Holder's DOB:		Sex:	❑ Male ❑ Female						
Policy Holder's Employer:		Relationship to Patient:	❑ Self ❑ Child ❑ Spouse ❑ Other						
Is your condition related to an injury or accident:	❑ Yes ❑ No	If yes, please indicate type:	❑ Auto ❑ Industrial ❑ Other						
Date of Injury:		State injury occurred in:		Claim Number:					
Claim Adjustor's Name:		Claim Adjustor's Phone Number:							

SECONDARY INSURANCE INFORMATION (PLEASE HAVE INSURANCE CARD ON HAND FOR COPIES)									
Secondary Insurance Company Name:									
Policy Number:		Plan Name/Group Number:							
Policy Holder's Name:									
Policy Holder's Address:		City:		State:		Zip:			
Phone Numbers:	Home:		Work:		Mobile:				
Policy Holder's DOB:		Sex:	❑ Male ❑ Female						
Policy Holder's Employer:		Relationship to Patient:	❑ Self ❑ Child ❑ Spouse ❑ Other						

Part 3: FINANCIAL AGREEMENT

About Your Bill

Welcome to the Riverwoods Advanced Diagnostic Imaging and Cardiovascular Centers. We are proud to have one of the finest collections of diagnostic imaging equipment in the world staffed with friendly and superbly trained personnel. There are $8.5 million of capital equipment and infrastructure at work for you in this center. You can expect to receive the highest quality in diagnostic imaging services performed in a professional manner by a courteous staff.

Our charges are set at the 75th percentile of a national charge master. Charges in a medical facility can be confusing and difficult to understand because of the many variances in insurance policies. We would like to explain our policy in the following situations:

1) If you are an uninsured self-paying patient, we provide a 50% discount off the billed charges for all services, with the exception of ultrasounds and x-rays, if payment is made at the time of service. If payment is not made at the time of service, then you are responsible for paying the entire charged amount.
2) If your insurance company has a contract with us (e.g. Medicare) we will bill your insurance company first. You will be responsible for co-payments at the time of service. You will also be responsible for any deductible and coinsurance. We will accept as full payment the discounted contracted rate with your insurance company once both its and your contractual obligations have been met.
3) If your insurance company has not allowed us to contract with it, we will nevertheless bill your insurance company. Many allow a swing-out option. Any money received will be applied toward your balance. It will likely cost you more to come to this facility. On a case by case basis, we may adjust your bill to be competitive with other options.

Our goal is to provide superb care at a fair price. Insurance benefits can be opaque and confusing. Our staff is happy to assist you in resolving claims issues, explaining the cost of procedures, and in preauthorizing with your insurance company. Should you have any questions regarding your bill, please call (801) 437-4895 and speak with our billing group.

Billing Statements

In the days or weeks following your procedure you will receive two statements:

1) A statement will come from your insurance company called an "Explanation of Benefits," or "EOB."	***DO NOT PAY. This is not a bill.***
2) A statement will come from Riverwoods Advanced Diagnostic Imaging and Cardiovascular Centers called a "Statement."	Any amount due will be reflected on this statement. If the statement does not reflect an adjustment (if the amount you owe is greater than what would be expected at an in-network facility) please contact us.

Financial Agreement

Assignment of Benefits/Medical Release/Consent for Treatment

With this form I acknowledge I have been provided a copy of the NOTICE OF PRIVACY from Riverwoods Advanced Diagnostic and Cardiovascular Centers and authorize the release and disclosure of portions of my medical record necessary to obtain reimbursement for myself and for my covered dependents. Please initial here to indicate that you've received a copy of our "Notice of Privacy Practices." Initials: _____ Date: _____ This authorization gives Riverwoods Advanced Diagnostic and Cardiovascular Centers the right to request and receive medical information from other health care entities and providers to include but not limited to copies of lab results, diagnostic test reports, films/images, and other clinical information deemed necessary by Riverwoods Advanced Diagnostic and Cardiovascular Centers, physicians or representatives. I understand I am not required to sign this authorization as a condition or my treatment, unless permitted by law. I also understand that I may inspect my protected health information, request more information, and revoke this authorization, as permitted by the federal privacy regulations and in accordance with Riverwoods Advanced Diagnostic and Cardiovascular Centers privacy policy.

I hereby consent to any medical treatment, x-ray, laboratory or other procedure, which the physician(s) may consider or advise in treatment of my case (or as legal guardian for patient). I hereby authorize any benefits due to be paid directly to Riverwoods Advanced Diagnostic and Cardiovascular Centers, 280 West Riverpark Drive, Provo, Utah 84604. This agreement will remain in effect until I choose to revoke it in writing.

Credit and Finance Charge Policy and Agreement

I understand and agree that I am financially responsible for all deductible amounts, co-insurance, non covered services or services deemed as "non-medically necessary" by my insurance carrier(s).

A finance charge (1.5% per month/APR 18%) may be added to any amount for which payment has not been received within 60 days from the date of the statement on which the amount first appears. The account must be paid within 90 days or a finance charge will be added on a monthly basis. I hereby agree to pay a service charge of $20 for each check or other instrument tendered by me but returned to this facility. A 33 1/3% collection fee and/or legal fees of 50% of the total amount due will be added to my account if sent to a collections agency. Additional service charges may be levied for accounts placed with third-party collection agencies or failure to make necessary co-payments at the time of service.

I agree to pay the co-pay, co-insurance or deductible amount I am responsible for as indicated on the Explanation of Benefits from my insurance company to Riverwoods Advanced Diagnostic and Cardiovascular Centers in a reasonable and timely manner. I understand that the amount I am responsible for as indicated on the Explanation of Benefits from my insurance will be considered delinquent if not paid within 60 days of receipt of the statement. I agree to be fully responsible for the following charges, services and actions on any delinquent amount I am responsible for as indicated on the EOB from my insurance company.

In consideration for medical services rendered, I (we) acknowledge that I (we) have received notice of the Riverwoods Advanced Diagnostic and Cardiovascular Centers financial policy and agree to pay for said medical services according to such terms.

Medicare Patient Agreement

Request that payment of authorized Medicare benefits be made either to me or on my behalf to Riverwoods Advanced Diagnostic Imaging and Cardiovascular Centers for any services furnished me by that provider. I authorize any holder of medical information about me to be released to the Center for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. This authorization is in effect until I choose to revoke it in writing.

ACKNOWLEDGEMENT. The Responsible Party has reviewed the Riverwoods Advanced Diagnostic Imaging and Cardiovascular Centers policies above and agrees to be bound by the terms and conditions of this account with Riverwoods Advanced Diagnostic Imaging and Cardiovascular Centers. I verify that the patient and insurance information I have provided is correct and complete.

Signature of Patient, Guarantor, or Guardian:		Date:	