

PARKVIEW IMAGING
2428 Santa Monica Blvd #LL
Santa Monica, CA 90404

Mission Statement

Our mission at Parkview Imaging is to provide you and your physician with the very best service possible. We strive to deliver the highest quality diagnostic imaging services available. To treat each and every patient with respect and dignity. And to provide caring medical attention. Your well being is very important to us. If for any reason you feel that your visit was not satisfactory please let us know.

Billing Statement

Although we bill all insurance plans we are **not** contracted with all insurance companies. If we are a network provider for your insurance company they will pay our services at the negotiated rate and we will apply the appropriate payments and adjustments to your account. **It is your responsibility to pay deductibles, co-payments, and any denied charges.** You must have "Out of Network " benefits if you use Parkview Imaging as a non-contracted, "out of network" provider. If your insurance company does not make payment you will be responsible for all incurred charges. It is **your** responsibility to know the provisions of your plan.

If pre-authorization is required, it is the responsibility of the **Patient** and or the **Ordering Physician** to assure that prior approval is obtained from your insurance carrier. Upon the completion of your exam we will bill your insurance. This does not guarantee payment. To reduce your out of pocket cost, our billing office will vigorously follow-up and appeal all denied claims. It is our hope to have your account settled as expeditiously as possible.

Definitions:

Deductible- The deductible amount depends upon the type of plan that you have with your insurance carrier. This is the amount that **must be paid by you prior to your insurance making any payments on your behalf.**

Co-Payment: This is the amount that is **determined by your insurance carrier** after the claim has been processed.

We thank you for your cooperation.

I have read and understand the above statements

Patient's signature: _____

Date: _____