Radiology Imaging Associates

7801 Old Branch Avenue, Suite 300
Clinton, MD 20735
(301) 856-6718 * (301) 576-5280 fax

PATIENT NAME: _____ ACCOUNT# _____

AUTOMOBILE INSURANCE (only if test today is auto related)

Were you the ☐ Passenger or ☐ Driver? **Date of Accident:_____**

Auto Insurance Carrier (of vehicle you were in) | Policyholder's Name | Auto Insurance Policy #

Claim # | Claim Mailing Address | City | State | Zip

Claim Adjuster's Name | Claim Adjuster's Telephone Number

WORKERS' COMPENSATION INFORMATION (only if test is related to a work injury)

Employer's Name (at the time of injury) | Address | City | State | Zip

Employer's Telephone # | Date of Injury | Workers' Compensation Insurance Carrier's Telephone #

Workers' Compensation Insurance Carrier Name | Address | City | State | Zip

Claim # | Authorization Number | Approved By | Telephone #

DO YOU HAVE OR PLAN TO OBTAIN AN ATTORNEY? *YES* ☐ *NO* ☐

Attorney's Name (please print): _____ Address: _____
Telephone number: _____ Fax Number: _____

In the event of a personal injury and / or a workers' compensation dispute pending or the potentiality that a claim or action will be filed concerning my injuries for which I am seeking treatment, I acknowledge full responsibility for all RIA medical bills incurred as a result of this injury. In consideration for RIA to coordinate benefits with an insurer of my injury, I agree to pay the total charge related to service provided either upon resolution of my case, or at the end of the 365 days from the date of initial service for this injury, whichever, is sooner. At the end of 365 days and if my charges have not been paid, I agree to begin making three equal consecutive monthly payments starting on the 366th day after my date of service. The payment schedule below will outline the estimated consecutive monthly payments due RIA. I understand that the payment schedule below is an estimate of the services I will receive from RIA. I agree the payment amounts may change depending on the need for additional services. I irrevocably authorize and direct any attorney that I retain to immediately pay RIA the total charge (less any payments already made), upon resolution of my case.

Patient or Responsible Party's Signature: _____ Date: _____

IS THIS A SELF-PAY ARRANGEMENT OR LITIGATION CASE? *YES* ☐ *NO* ☐

Self-Pay / Patient Agreement

Estimated Total Charge $ _____ | Payment # 1 Due _____ | Estimated Amount Due $ _____

Amount Paid Today $ _____ | Payment # 2 Due _____ | Estimated Amount Due $ _____

Estimated Remaining Balance $ _____ | Payment # 3 Due _____ | Estimated Amount Due $ _____

Please make checks payable to: "RIA" and mail to 7801 Old Branch Avenue, Suite 300 Clinton, MD 20735. Please note your account number on your check. If you need to make any other financial arrangements during the course of this agreement, you must contact our Customer Service Department at 301-856-6718 immediately.

I, (Attorney's Name) _____, acknowledge this patient payment agreement and will comply with and / or direct my client to comply with these terms.

Attorney's Signature: _____ Date: _____

Patient or Responsible Party's Signature: _____ Date: _____

RIA Witness: _____ RIA 202, Side 1, rev. 12/06