



1320 22nd Ave
Fairbanks, Alaska 99701
(P) 452-4777
(F) 452-4787

Intent to Pay

I understand that Fairbanks Community Imaging will make every effort to bill and collect payment from my insurance company for the services that I am about to receive. Although I have coverage from the entity that I have provided with Fairbanks Community Imaging with for billing purposes, **I understand that the insurance company may reject the bill and not cover my services.** Therefore, I agree to be responsible for the balance that will be brought forth to me in case the insurance company does not cover the service(s).

In the event that I am unable to provide Fairbanks Community Imaging with my complete insurance information at the time of service, I will have 48 hours to call or fax the information. If I am unable to do so, I am aware that I will be responsible for the balance of my account.

Patient or Responsible Party Signature

Date

OFFICE USE ONLY

Patient Name: _____

Responsible Party Name: _____

Date of Service: _____

MM# _____