

X-RAY SERVICES FOR THE PATIENT:

On the day of your procedure, please bring all insurance cards and/or forms.

Pacific American Medical Service will provide your x-ray services during your procedure.

Pacific American Medical Service has a separate contract with the surgery center/ doctors office.

Our charges are not included in the Physician/Surgeon fees or the Facility/Surgery Center fees.

Therefore you may see separate charges or fees on your insurance statement related to your procedure, also known as your Explanation of Benefits (or E.O.B.)

We are considered an out of network provider with most insurance carriers (but not all). We do accept workers compensation claims and Medicare. A claim will be filed on your behalf by Pacific American Medical Service.

You may have benefits or payments sent directly to you from your insurance carrier. These payments and/or any deductible/co-payment amounts are your responsibility. Keep in mind these benefits or payments may directly cover your outstanding charges with Pacific American Medical Service.

Dear Patient:

This letter addresses radiology services you will be having at this facility. Pacific American Medical Service, Inc. (PAMS) will be providing your x-ray/fluoroscopy services during your procedure. Our charges are not included in the physician/surgeon fees or the facility fees. You may see separate charges or fees on your Explanation of Benefits (EOB) related to your procedure from PAMS. We accept most insurances, including Workers Comp. However, we do not participate with all insurances. A claim will be filed on your behalf. Your insurance company may send the check for our services directly to the subscriber. Should this occur, please forward the payment to:

Pacific American Medical Service, Inc.
5288 Eastgate Mall, Suite A
San Diego, CA 92121

If you have any questions regarding our services please call the billing department toll free at (866) 943-4589 option 1.

ASSIGNMENT OF BENEFITS:

I authorize payment of medical benefits to the provider of services rendered or to be rendered in the future, without obtaining my signature on each claim submitted, and my signature below will bind me as though I personally signed the claim. I authorize the release of any medical or other information necessary to process my medical claims. I also authorize payment of government benefits either to myself or to the party who accepts assignment. I have read and understand this policy and procedure.

Patient Signature- or Representative

Date

Print Name

Relationship to Patient