Montclair Breast Center

FINANCIAL ACKNOWLEDGEMENT

Montclair Breast Center participates with Medicare and some commercial insurance plans. Please check with one of our staff members or on our website to verify if your plan is in-network. It is your responsibility to know your insurance plan. Most claims are submitted electronically including out-of-network claims. If you are utilizing out-of-network coverage your insurance will reimburse you depending on your plan's coverage.

You are responsible for any charges incurred in this office. For **out-of-network** members payment is due in full at time of service. **Out-of-network** members knowingly, voluntarily and specifically selected Montclair Breast Center with full knowledge that this provider is out of network with your health care plan. For **in-network** members you are responsible for copays, coinsurance and deductibles. Your signature on this document indicates that you agree to pay for any outstanding charges incurred in this office whether your plan is in-network or out-of- network.

To ensure that claims are processed correctly, please update any changes regarding your insurance company and/or demographics such as: place of residence, marital status and name change.

Please be aware any outstanding balances remaining on your account for more than 3 months will be sent to collections. Attempts will be made to notify you and arrange payment options prior to sending to collections and you will be responsible for the balance plus collection fees.

There will be a $50 fee for any bounced checks and the option to repay with a check may not be available to you.

My claims submission choice is:

☐ I hereby authorize Montclair Breast Center to provide a copy of and/or disclose information related to my medical records or other information regarding me in your possession, to my insurance carrier(s) or other authorized third- payer) and their review organizations, as needed for purposes of determining my benefits for services, for filing a claim for obtaining payment for services and for other purposes as allowed by law

☐ I do not authorize Montclair Breast Center to mail claims to my insurance company.

I have read the above office financial policy; I agree and understand the terms.

_____ _____

(PATIENT SIGNATURE) (DATE)