Montclair Breast Center
37 N. FULLERTON AVE., MONTCLAIR, NJ 07042

FINANCIAL ACKNOWLEDGEMENT

Montclair Breast Center participates with some Horizon BCBS plans, please check with a staff member to verify if your plan is one of the ones we are contracted with. 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 the coverage of your plan.

You are responsible for any charges incurred in this office. For out-of-network members, the payment is due in full at time of service. For participating members, you are responsible for deductibles, copay and/or coinsurance. Your signature on this document indicates you agree to pay for any outstanding charges incurred in the office.

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 balance remaining on account for 3 months will be sent to collections. Attempts will be made to notify you and arrange payment options prior to sending to collection and you will be responsible for the balance plus collection fees.

There will be a $35 fee for any bounced checks and option to repay with a check may not be available to you.

Please select one appropriate option below:

☐ 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(s) 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.

For patients utilizing their out-of-network benefits:

☐ I knowingly, voluntarily and specifically selected Montclair Breast Center with full knowledge that this provider is out-of-network with my health care plan.

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

Patient Signature: _____ Date: _____