Montclair Breast Center

37 N. FULLERTON AVE., MONTCLAIR, NJ 07042

FINANCIAL ACKNOWLEDGEMENT FOR OFFICE PROCEDURES

Name _____ D.O.B. _____ ID# _____

Procedure _____ Doctor _____

Montclair Breast Center has called your insurance company for authorization:

- ☐ No Authorization Needed
- ☐ Authorization # _____.

Please be aware per insurance companies, authorization does not guarantee payment.

Montclair Breast Center participates with some Horizon Blue Cross Blue Shield 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.

Please initial the below statements to indicate your understanding that you may be responsible for the following:

In-network patients:

1. Coinsurance, in-network deductible and copay. _____ (Initial)
   Depends on your plan. Some plans have no in-network deductible. It is your responsibility to know your plan.

Out-of-network patients:

1. You are responsible for 100% of the charges. A claim will be sent to your insurance to help you obtain reimbursement. Your reimbursement is based on your plan and may be less than what you paid.
   _____ (Initial)

2. For Non-Par members - Services not covered by your insurance. Your out of pocket responsibility is $_____

3. If you paid in full at the time of service, you may keep the reimbursement check sent by your insurance. Otherwise, you agree to forward the insurance payment within 7 days of receiving the payment. Due to credit card fees on our end, we prefer that you send a check if the insurance paid you by check.
   _____ (Initial)

4. The total charge being sent to your insurance company is $_____.

5. Most insurance reimburses at a reduced rate for multiple procedures done on the same day. Your insurance will approve 100% of first biopsy and 50% of second, if done on the same day. Depending on your out-of-network coverage they will pay a percentage of the approved rate. If you are having a multiple biopsy procedure today, by this initial you understand you have the right to schedule on a different day.
   _____ (Initial)

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☐ BIOPSIES

1. Tissue samples will be sent to a laboratory to be analyzed by a pathologist. Please be advised you will receive a separate bill from the LAB for any specimens sent in for pathology. They are a separate entity, please contact them directly for any questions regarding your bill at Livingston Pathology Associates (855) 874-1596. _____ (Initial)

Please select one:

☐ 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. _____ (Initial)

☐ I do not authorize Montclair Breast Center to send a claim or medical records to my insurance company. I understand by selecting this option I am responsible for payment in full of $_____ and agree not to send a claim myself to insurance for reimbursement. Should I decide to change my mind later and try to seek reimbursement, the self-pay agreement is voided. I will be responsible to send Montclair Breast Center any additional payments I receive from insurance. _____ (Initial)

Your signature below is acknowledgement of the following:

You acknowledge that you're responsible for services performed at Montclair Breast Center. You understand that although you may have insurance to cover the cost of treatment, you remain responsible for payment and for the claim status making sure your insurance carrier receives and reviews the claim for services rendered. Montclair Breast Center will be responsible for claim status for Horizon Blue Cross Blue Shield in-network plans only.

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.

_____ _____

(SIGNATURE) (DATE)