## FINANCIAL ACKNOWLEDGEMENT

Montclair Breast Center participates with certain plans within Horizon Blue Cross Blue Shield, UnitedHealthcare, Oxford and Medicare. Please check with a staff member to determine if Montclair Breast Center participates with your insurance plan. 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 may reimburse you and not Montclair Breast Center. If you are reimbursed by your insurance, you are responsible to make payment to Montclair Breast Center for the services provided.

You are responsible to pay for all services provided to you by Montclair Breast Center. 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 for the services performed by Montclair Breast Center.

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 collections. If your past due account is sent to collections, then you will be responsible for the outstanding 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.

**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 submit 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 Financial Acknowledgement and by signing below, I agree and understand the terms and my payment responsibilities.**

_____ _____

SIGNATURE) (DATE)

12.2021