Montclair Breast Center

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 prior authorization does not guarantee the claim will be paid.

Montclair Breast Center participates with certain plans within Horizon Blue Cross Blue Shield, UnitedHealthcare, Oxford and Medicare. Please check with a staff member to verify if we are contracted with your plan. **It is your responsibility to know your insurance plan.** Most claims are submitted electronically, including out-of-network claims. Whether an in-network (Par) or out-of-network (Non-Par) claim is reimbursed is dependent on the coverage of your plan.

Please initial the statements below that you understand and agree to your payment responsibilities:

In-network patients:

1. Coinsurance, in-network deductible and copay. _____ (Initial)

It is your responsibility to know your plan and if you owe coinsurance, copay and/or a deductible.

Out-of-network patients:

1. You are responsible for 100% of the charges. A claim will be sent to your insurance for 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. For example, your insurance may approve reimbursement at the rate of 100% for the first biopsy and 50% for the second biopsy, if done on the same day. You may request if multiple biopsies are needed that they be performed on separate days. Depending on your out-of-network coverage they will pay a percentage of the approved rate. _____ (Initial)

12.2021

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☐ BIOPSIES

- Tissue samples will be sent to a laboratory to be analyzed by a pathologist and you will receive a separate bill for the pathology services performed. Please contact Livingston Pathology Associates (855) 874-1596 directly with any questions regarding your bill or for a list of participating insurances. _____ (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)

<u>Your signature below is acknowledgement of the following:</u>

You acknowledge that you are 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. For the plans that Montclair Breast Center is a participating provider within Horizon Blue Cross Blue Shield, UnitedHealthcare, Oxford and Medicare, Montclair Breast Center will be responsible for the status of the claim.

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

_____ _____

(SIGNATURE) (DATE)