

# Montclair Breast Center

## FINANCIAL ACKNOWLEDGEMENT FOR SURGERIES

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)

**FACILITY CHARGES FOR SURGERY:** Please be advised that there are facility, anesthesia and pathology fees for procedures performed at the following locations. Please contact the offices for the facility, anesthesiologist or pathologist directly at the numbers below with any insurance and billing questions.

North Fullerton Surgery Center (973) 233-0433

Barnabas Ambulatory Surgery Center (973) 322-7000

Livingston Pathology Associates (855) 874-1596

# Montclair Breast Center

Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ ID# \_\_\_\_\_

- **North Fullerton Surgery Center** is a facility in-network only with Horizon Blue Cross Blue Shield, UnitedHealthcare, Oxford and Medicare. If you are utilizing out-of-network coverage, you will be responsible for 100% of the charges. \_\_\_\_\_ (Initial)
- **Saint Barnabas Medical Center** may participate depending on your plan. Fees will vary according to the type of procedure(s) that is (are) being performed. The services performed will be billed to your insurance company. If your insurance is out-of-network, then Saint Barnabas may send you a bill for the difference between the amount charged and the amount paid by your insurance, which is called a Balance Bill. If you are utilizing out-of-network coverage, you will be responsible for 100% of the charges. \_\_\_\_\_ (Initial)

**ANESTHESIA:** A board certified anesthesiologist will be present for your procedure and will send you a separate bill. \_\_\_\_\_ (Initial)

**PATHOLOGY:** 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. \_\_\_\_\_ (Initial)

#### PAYMENTS REQUIRED PRIOR TO SURGERY

- I understand for date of service \_\_\_\_\_ the fee for Montclair Breast Center is payable prior to the surgery. \_\_\_\_\_ (Initial)
- For Insurances with facility capitation or for patients with no insurance; Facility fees are due 1 week prior to surgery \_\_\_\_\_ (Initial)  Check here if this does not apply to you.

#### 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-party 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)

(Please Note: Montclair Breast Center will receive notice of the processed claim and will send a corrected claim to reflect our full rates.)

**Your signature is acknowledgement of the following:** 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)