Montclair Breast Center
Expertise · Experience · Compassion

NON PAR FACILITY ACKNOWLEDGEMENT

MONTCLAIR BREAST CENTER FINANCIAL ACKNOWLEDGEMENT

Montclair Breast Center does not participate with insurance. However, we will generate a claim so that you may seek reimbursement through your out of network benefits. We will also call to verify your coverage on your behalf, if needed. For these reasons, we ask that you please present your primary and secondary insurance cards to the receptionist.

In the event that there are any outstanding balances on your account, by signing below you agree to bring in all explanation of benefits and checks due to Montclair Breast Center. It is important to keep all explanation of benefits and checks intact so that we know what dates of service they apply to.

Our practice is committed to providing the highest quality of treatment to our patients. Please be aware our fees are above reasonable and customary for our area and patients are responsible to make payment in full.

It is your responsibility to know your out of network coverage. If you have any difficulties acquiring this information or need help to understand your benefits, our financial office is available to assist you.

Montclair Breast Center is committed to providing the best care and in return we ask for your commitment in keeping your appointments. If in the event you have no other alternative and your appointment must be rescheduled or cancelled please inform the office 48 business hours in advance.

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 am aware that should the services of a third party collection agency and/or attorney be required to collect a debt for services rendered by Montclair Breast Center, I will be responsible for all costs of collection of that dept.

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

_____ Date _____

Signature of Patient or Responsible Party