THE Breast CENTER
Specialists In Breast Care

Chart #

Office Use Only

CONSENT AND RELEASE

1. The undersigned patient, or authorized individual acting on behalf of the patient, understands and agrees as follows:
2. Patient or legal custodian authorized the Staff Physician(s) or Nurse Practitioner to examine and treat the above patient
3. The Breast Center is granted permission to release to the insurance carriers, referring physician and primary care physician any information deemed necessary, as may be requested, relating to any treatment rendered to patient.
4. Patient or legal custodian shall agree to pay to The Breast Center such sums as are, or may become, due for services rendered to the patient. All co-pays and deductibles being due and payable at the time of service.
5. In the event that the patient's insurance company does not make full payment on this obligation, all balances will be due and immediately payable by the patient and /or legal guardian.
6. A returned check fee of $35 will be assessed on any and all returned checks.
7. Delinquent accounts will be assessed all collection, legal, and administrative costs to the fullest extent of the law.
8. Patient or legal guardian understands that if their insurance company requires that a referral be issued, it must be received at the time of service. If seen without a valid referral the patient accepts responsibility for full payment at the time of service with the understanding that no claim will be filed with the insurance carrier.
9. Our fees for surgical procedures will vary depending on the complexity of your problem and the service provided. If the surgical procedure is performed outside of our facility, we will assist you in pre-certification, second opinion, etc. We will ask for the patient's portion of the surgical bill prior to surgery (outstanding deductible and / or copay). You will receive separate bills from the surgery facility, lab, etc.
10. If payment of charges imposes a financial burden, we ask that you speak to the account manager for specific payment arrangements. We will make every effort to assist you with your needs.

INSURANCE PAYMENT PLAN

We will file insurance with your provider according to your individual plan. The patient will be responsible for any outstanding deductible, their 20% and/or co-pay. Referral numbers required by some insurance companies must be given at the time of service, otherwise the service becomesthe patient's responsibility. For all private insurance companies, the patient will be responsible for payment at time of service. We will provide the necessary information for the patient to file for reimbursement.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I hereby authorize payment directly to the physician of the surgical and/or medical benefits, otherwise payable to me for services as described, realizing that I am responsible to pay for non-covered services.

Patient / Guardian Signature _____ Date _____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the physician to release any information required in the course of my treatment necessary to process insurance claims.

Patient / Guardian Signature _____ Date _____

The Breast Center, P.C.

Consent and Release

The undersigned patient, or authorized individual acting on behalf of the patient, understands and agrees as follows:

- Patient or legal custodian authorized the Staff Physician(s) or Nurse Practitioner to examine and treat the patient.
- The Breast Center is granted permission to release to the insurance carriers, referring physician and primary care physician any information deemed necessary, as may be requested, relating to any treatment rendered to patient.
- Patient or legal custodian shall agree to pay to The Breast Center such sums as are, or may become, due for services rendered to the patient. All co-pays and deductibles are due and payable at the time of service.

I hereby authorize and assign all payments and/or insurance benefits for medical services and/or surgical procedures rendered to me directly to The Breast Center. I hereby authorize The Breast Center to release any information necessary to process my claim. I understand that I am legally and financially responsible for all charges not covered by my insurance plan. I hereby authorize payment directly to The Breast Center for services rendered.

I understand if my insurance plan sends me a check for payment of the medical services provided by The Breast Center, the check belongs to The Breast Center and I must immediately deliver the check to The Breast Center for payment on my account.

In the event that my insurance plan denies my claim and I choose to appeal their decision, this form and my signature authorizes The Breast Center to submit an appeal along with any necessary medical information to my insurance plan.

_____
Print Name

_____
Signature

_____
Date

Name of Patient if Signed by Legal Guardian: _____

Revised 06/23/2014