BREAST CENTER
of ACADIANA

INSURANCE AND PAYMENT POLICY, RELEASE AUTHORIZATIONS AND ACKNOWLEDGEMENT

The Breast Center of Acadiana is committed to making your experience with us as pleasant as possible. We want to make healthcare less stressful and more effective by clarifying financial responsibilities in advance. The following is a statement of our financial policy, which we ask that you read and sign where indicated.

INSURANCE AND PAYMENT POLICY

Your insurance policy is a contract between you and your insurance company. It is important that you contact your insurance prior to your visit to assure that we are a participating provider. Your insurance company will also be able to inform you if a referral is required or if precertification is needed prior to services being rendered. It is your responsibility to determine if services will be covered and if your deductible has been met.

We will bill most insurance carriers for you if proper information has been provided to us. If payment has not been made by the insurance company within 45 days, the unpaid balance will become your responsibility. All outstanding patient balances over 120 days from the original date of service without payment arrangements may be turned over to a collection agency. If Medicare is your primary insurance, we will file all claims and accept assignment for related services.

Co-payments and/or deductibles are due at the time of service. We accept payment in the forms of cash, check, Discover, Visa, Mastercard and American Express credit cards. There will be a $25 fee for all returned checks. Self-pay patients are required to pay at the time of service.

If you have any questions or concerns about billing, please call the billing office at (337)504-5000 (you may leave a message after business hours).

AUTHORIZATION TO RELEASE INFORMATION

I authorize Breast Center of Acadiana to furnish my protected health information to my insurance company concerning my illness and treatment for payment purposes. I hereby assign all benefits payable directly to Breast Center of Acadiana for services rendered. I understand that in the event my insurance denies this claim, I will be held financially responsible for all charges.

Patient Name _____ DOB_____

Signature of Patient/Guardian _____ Date _____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO CERTAIN PERSONS

I authorize Breast Center of Acadiana to furnish my protected health information to the following individuals, all of whom are involved in my care for any purpose related to my treatment or the payment of my care. This agreement is in effect until otherwise revoked in writing by the Patient/Personal Representative.

Name _____Phone # _____

Name _____Phone # _____

Signature of Patient/Guardian_____ Date _____

ACKNOWLEDGEMENT RECEIPT OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received the Notice of Privacy Practices of Breast Center of Acadiana, which explains its legal duties and privacy practices with respect to my protected health information. I understand that I may refuse to sign this acknowledgement.

Signature of Patient/Guardian _____ Date_____