Financial Policy & Authorization form

Thank you for choosing Georgia Breast Care, PC! We are committed to meeting your healthcare needs. Georgia Breast Care accepts most insurance plans; however, it is the patient's responsibility to confirm with our office and the insurance carrier.

INSURANCE PAYMENTS: Insurance is a contract between you and your insurance company. You are ultimately responsible for payment of the charges for services received from Georgia Breast Care, PC, including those covered by your insurance. As a convenience, Georgia Breast Care, PC will submit claims for reimbursement with your insurance provider. It is your responsibility to provide the most current insurance information available as well as any changes in your address, name, telephone information, or email address at each visit. If Georgia Breast Care is provided with incorrect insurance information, you will be responsible for the remaining balance. Your insurance carrier makes the final determination of your eligibility and benefits. To satisfy your financial obligation, you agree to provide Georgia Breast Care, PC and/or its designated payment agent with your debit/credit card, ACH information, cash, check, or money order. We accept VISA, MasterCard, American Express, and Discover.

MEDICARE: We accept Medicare assignment. If you have a supplemental insurance, we will bill it directly. If you have a Medicare Advantage plan, you are required to pay your co-pay at the time of service. Medicare patients are responsible for their annual deductible and co-insurance.

PATIENTS WITH A HMO: It is your responsibility to know and understand your HMO medical plan. If your HMO requires a ***referral*** for a consultation, you are responsible for obtaining it and submitting it to us ***prior*** to your visit. Also, it is your responsibility to confirm with your insurance company that we are in network with your plan. If you do not have a referral for today's visit, it is recommended you reschedule your appointment.

PATIENTS WITH A PPO: You are responsible for your co-pay, deductible, and your co-insurance. Co-payments are due at the time of your visit. It is your responsibility to verify with your insurance carrier that we are contracted with your plan.

SELF-PAY: You are required to pay the self-pay rate at the time of your visit.

PAYMENT POLICY: Payment is expected in full within 30 days of receipt of your patient statement. You may generally expect this billing statement within 20 days after your insurance company has responded to a submitted claim. If payment is not received within 60 days, your account is considered past due. The policy of this office is to only send 2 statements. The statements are sent at approximately 30-day intervals. If no payment is received on your account during the 60-day grace period, your account will be turned over to collections without additional notice.

PAYMENT PLANS: Georgia Breast Care, PC is willing to work with you to assist you in paying your outstanding balance. We do have an established payment plan program for an outstanding account balance. Balances may be divided into no more than 4 monthly payments. A valid credit/debit card must be presented at the time the plan is established. Your signature on our payment plan form is required. Your signature acts as your authorization for us to charge your card on a monthly basis. This authorization remains in effect until the outstanding balance is zero.

SURGERY CHARGES: Prior to surgery, Georgia Breast Care will contact your insurer to obtain pre-certification and verify benefits. This process does ***not*** guarantee payment by your insurance carrier. You agree to facilitate payment of claims by contacting your insurance carrier when necessary.

IN-OFFICE PROCEDURES: Georgia Breast Care, PC will contact your insurer to obtain pre-certification and verify benefits as well as ***estimate*** your out-of-pocket expenses based on your coverage and benefits. You will be required to pay in full this amount ***prior*** to the procedure. This process is not a guarantee of your final out-of-pocket expense for the procedure.

SURGICAL CANCELLATIONS: If you need to reschedule/cancel a surgical procedure, a 3-business day notice is required. Failure to cancel the procedure by notifying our office may result in a $150.00 non-refundable administrative fee. This fee must be paid before rescheduling.

OUT OF OFFICE SURGICAL PROCEDURE: You will receive a statement from Georgia Breast Care, PC for the physician's fee for your surgical procedure. Also, you will be billed separately by the surgical center for their facility charges. Additionally, if a specimen is sent to a lab for analysis, you will receive a bill from the lab. Finally, if you receive anesthesia services, you will receive a statement from the anesthesiologist. Georgia Breast Care, PC does not handle charges billed for the facility, lab, or anesthesiologist.

LAB SERVICES AND OTHER ANCILLARY SERVICES: Depending on the services provided, you may receive statements for ancillary services. Please understand that we cannot know which tests are covered by your individual insurance as each insurance plan is different. Also, we send all lab specimens to an outside lab, and the lab will bill you separately. Please advise in advance if your insurance plan requires a specific lab. For anesthesia or lab services, please direct any questions or disputes to their billing offices. Each of these charges will be based on your insurance coverage and benefits.

RETURNED CHECK FEE: A 35.00 fee will be assessed on all returned checks.

CO-PAYS: We are required to collect co-pays, deductibles and co-insurance per our contracts with insurance carriers. These amounts cannot be negotiated or waived**. Co-pays are expected at the time of service**. If you are unable to pay your co-pay, you will need to reschedule your appointment.

CODING CHANGES FOR SERVICES PROVIDED: Many insurance companies have restrictions on the type of services that are covered by their policies. Government regulations dictate that all health care providers must submit claims that accurately reflect the services that are provided as well as documented in the patient's medical record. Our office is under strict guidelines that demand we code services/orders to the highest level of accuracy. **Please do not ask our staff to change coding or diagnosis codes for the purpose of getting your insurance to make payment on services rendered**.

We strive to provide excellent medical care to you and to all our patients. Consistent with this, we have developed missed appointments, late cancellation and no show policies that allow us to better schedule appointments for all patients. When an appointment is scheduled, that time has been specifically reserved for you and when it is missed, that time cannot be used to treat another patient in need of care. We sincerely appreciate your assistance and cooperation as this allows for a smooth office flow and more efficient use of your time.

MISSED APPOINTMENT FEE: Failure to cancel an appointment 3 business days in advance will result in a $50.00 fee.

LATE ARRIVAL FOR APPOINTMENT: If you arrive late for your appointment, it is highly unlikely that we will be able to offer you an appointment the same day and your account will be assessed a $50.00 fee. We realize that some events such as traffic and other emergencies occur. Please call our office to speak with our staff as soon as possible in this situation.

CANCELLED APPOINTMENTS: For our returning patients, we provide an appointment reminder card at the conclusion of your visit for your next visit. As a courtesy to our patients, we send out a text confirmation message 7 days prior to your appointment. The text message will allow you to confirm or cancel your appointment. If you do not respond to the text message, you will receive another text message 6 days prior to your appointment that will allow you to confirm or cancel your appointment. It is very important that we have up to date contact information so that you will be able to receive communication from our office. If you do not cancel your appointment, we will assume that you will be attending your appointment and prepare accordingly. If you fail to provide our office with the courtesy of cancelling or rescheduling your appointment at least 3 business days, your account will be assessed a $50.00 fee.

REPEAT CANCELLATION/RESCHEDULE/NO SHOW OF ESTABLISHED PATIENT: Established patients who have an excessive history of late cancellations, missed appointments, or a combination of the two will be subject to discharge from the practice.

Ultimately, it is your responsibility to keep up with your scheduled appointment. You are always welcome to call our office for any clarification or rescheduling needs. Also, your patient portal will have your appointment information for your use as well. In addition, you are able to submit a cancel/reschedule request via your patient portal.

COMMUNICATION METHODS FOR PATIENT ACCOUNT: Georgia Breast Care, PC may contact you with any phone number associated with your account, including wireless numbers which could result in charges to you. In addition, you may be contacted via mail, email, text message, a pre-recorded/artificial voice message, and/or use of an automated dialing service as applicable.

QUESTIONS: *If you have any questions about Georgia Breast Care's financial policy or your insurance authorization/reimbursement, you may discuss them with Georgia Breast Care's business office staff.*

AUTHORIZATION:

- I authorize the release of any medical information necessary to process a medical claim to my insurance company.
- If my insurance carrier denies my claim and I choose to appeal the decision, Georgia Breast Care may submit an appeal with any necessary medical information to my insurance company on my behalf.
- I authorize Georgia Breast Care, PC to charge my copay and/or account balance to my credit/debit card with the information provided by me.
- I authorize that Georgia Breast Care's Notice of Privacy Practices has been made available to me. I have the opportunity to ask questions as needed.

I have read and understand my financial responsibilities under this policy. This authorization will remain in effect until I provide written notice of cancellation to the practice. Authorization for services already rendered cannot be cancelled or refunded. I agree to notify Georgia Breast Care, PC in writing of any changes in my payment or other information.

_____	_____/_____/_____	_____/_____/_____
Patient Name (print)	**Date of Birth**	**Date**
_____	_____	
Patient Signature	**Responsible Party (if not the patient)**	

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