



**Montclair Breast Center**

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www.montclairbreastcenter.com

**ACKNOWLEDGEMENT**

PLEASE PRESENT PRIMARY/SECONDARY INSURANCE CARDS TO RECEPTIONIST.

Due to the recent changes in the healthcare insurance industry we are required to have you sign and date this form. It is your responsibility to know your insurance coverage. In the event that you fail to notify us about any changes in your coverage you hereby agree to have those claims become your responsibility.

Regarding Non-Participating Insurance's "Usual and Customary Rates": Our practice is committed to providing the highest quality of treatment to our patients, and please be reminded that your insurance company will determine what is reasonable and customary for reimbursement.

MONTCLAIR BREAST CENTER IS A NON-PARTICIPATING FACILITY WITH ALL INSURANCE COMPANIES INCLUDING MEDICARE. PLEASE BE AWARE THAT YOU ARE RESPONSIBLE FOR ALL DEDUCTIBLES OWED FOR ANY GIVEN PROCEDURE. MONTCLAIR BREAST CENTER IS FEE FOR SERVICE. PAYMENT IS DUE IN FULL AT TIME OF SERVICE.

FOR OUR MEDICARE PATIENTS:

Medicare will not pay for routine exam or screening ultrasound. If you choose to have an exam or ultrasound performed by the doctor, please be advised that the full fee will be charged. Screening mammograms are paid after 12 full months have passed since the previous mammogram. Authorization is not a guarantee of payment. It is your responsibility to pay for all balances due.

Thank you for your cooperation regarding this matter. Please let us know if you have any questions or concerns about our financial policy.

*I understand that my insurance may require my medical records/information for services, filing a claim and other purposes required by law. I hereby authorize Montclair Breast Center to send copies of and/or disclose my medical records/information to my insurance company. Montclair Breast Center has advised me that they do not participate with any insurance carriers including Medicare, therefore it is my responsibility to understand my out-of-network benefits.*

*I have read and understand the above office Financial Policy and agree to it's terms.*

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Signature of Patient or Responsible Party

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Date