

INSURANCE BILLING AGREEMENT

Dear Patient:

Your health, and the success of your treatment is always our primary concern. In order to ensure the best possible care, we must be able to deliver treatment in a timely manner.

As always, we continue to provide our patients with the service of requesting authorizations for treatment, and insurance billing. However, our relationship is with you, not with your insurance company, and due to the increasing complexity of insurance plans we cannot investigate each individual's insurance policy(s). It is the responsibility of the patient to know and understand his/her own benefits and coverage, and whether our providers are contracted (in-network) under the plan.

Without complete and accurate insurance information from you, we cannot obtain referrals and authorizations in time to treat you. If an authorization or referral is required under your particular plan, and we are unable to obtain these by your appointment date, we will require that you pay for the visit or treatment out-of-pocket, or that your appointment be rescheduled. As always, we will do everything we can to assist you in getting reimbursed by your insurance company.

We thank you for your cooperation in this matter.

Patient Agreement:

I, _____ (patient name) have provided Bay Area Breast Surgeons with the most current and accurate insurance information available to me. I understand that payment for any treatment not authorized by my insurance company is my responsibility.

Patient signature