

GENERAL PRACTICE GUIDELINES FOR PATIENTS

PLEASE READ THE FOLLOWING CAREFULLY. IT MUST BE SIGNED BY YOU OR YOUR GUARDIAN IF YOU ARE NOT 18 YEARS OLD.

ORIGINAL ON YOUR PATIENT FILE AFTER SIGNING, COPY PROVIDED AT YOUR REQUEST.

1. ASSIGNMENT OF BENEFITS

I HEREBY ASSIGN ALL MEDICAL AND/OR SURGICAL BENEFITS INCLUDING MAJOR MEDICAL BENEFITS TO WHICH I AM ENTITLED, INCLUDING MEDICARE, AND OTHER PRIVATE INSURANCE, AND ANY OTHER HEALTH PLAN TO:

COMPREHENSIVE BREAST CARE ASSOCIATES, PC

THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS AN ORIGINAL. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT.

SIGN

DATE

SIGN OF GUARDIAN

DATE

2. YOU WILL BE RESPONSIBLE FOR PROCESSING YOUR OWN SECONDARY OR TERTIARY INSURANCE CLAIMS. WE WILL BILL YOU DIRECTLY FOR ANY AMOUNT THAT IS OUTSTANDING FROM YOUR PRIMARY INSURANCE. PAYMENT IS REQUESTED WITHIN 30 DAYS FROM THE DATE YOU RECEIVE OUR NOTIFICATION OF A BALANCE DUE.

SIGN

DATE

3. As you may be aware, your insurance policy is a contract between you and your insurance company. We can only submit the claim for you; we cannot guarantee payment of the claim. Should your claim be rejected or only partially paid, your insurance company should send you an explanation of benefits. Ultimately, financial liability is your responsibility. I have reviewed the 3 items outlined on this page.

SIGN

DATE

4. I WAS INFORMED THAT THE PHYSICIAN TREATING ME DOES NOT PARTICIPATE WITH MY INSURANCE COMPANY AND THAT I WILL BE RESPONSIBLE FOR THE BALANCE OF CHARGES.

INITIALS PRACTICE

Change notification

I have not made any changes in my insurance coverage since my last visit.

SIGNED

DATE

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Comprehensive Breast Care Associates, PC.

The Comprehensive Breast Care Institute
At DSI of Bucks County
3300 Tillman Drive
1st Floor, MOB
Bensalem, PA 19020
Phone: 215-633-3456
Fax: 215-245-5941

COPAYS ARE DUE AT THE TIME OF YOUR VISIT

DATE:	SPOUSE'S NAME:
PATIENT NAME:	SPOUSE'S DATE OF BIRTH:
ADDRESS :	SPOUSE'S SOCIAL SECURITY#:
CITY, STATE, ZIP:	SPOUSE'S PHONE AT WORK:
PHONE: DATE OF BIRTH: (HOME):	EMERGENCY CONTACT: NAME:
(WORK): AGE:	RELATIONSHIP:
	PHONE:
INSURANCE IF DEPENDENT, PLEASE ENTER POLICY HOLDER AND DATE OF BIRTH:	INSURED'S OCCUPATION: INSURED'S EMPLOYER:
SOCIAL SECURITY#:	NAME OF PATIENT'S PRIMARY PHYSICIAN:
REASON FOR VISIT:	NAME OF PATIENT'S REFERRING PHYSICIAN:

**IS YOUR INSURANCE IN (CIRCLE ONE) YOUR NAME SPOUSE'S NAME OR PARENT'S
NAME**

DO YOU NEED A REFERRAL FOR THIS VISIT? (CIRCLE ONE) YES NO

IS YOUR REFERRAL (CIRCLE ONE) PAPER OR ELECTRONIC

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at DSI of Bucks County
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PRIVACY PRACTICES ACKNOWLEDGMENT

Upon request, a copy of our Notice of Privacy Practices will be provided for your review.

I wish to be contacted in the following manner (check all that apply):

Home Telephone_____ Written Communication_____

Leave message with detailed information Mail to home address

Leave message with callback number Fax to this number

Work Telephone_____ Other_____

Leave message with detailed information

Leave message with call back number

In signing this release, I authorize my medical records be faxed or mailed upon my request.

Name_____ Birthdate_____

Signature_____

Date_____