

Breast Care Center of Florida

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CONCERNING INSURANCE COVERAGE

1. In order to meet the needs of our patients, we have enrolled in various managed care programs. As you can imagine, keeping up with all of the individual requirements for each of these insurance companies can be practically impossible. Each program may have different requirements or stipulations that dictate which services can be provided, how often they may be provided, and who may be providing them. These rules can vary even in the same company with varied programs being offered.
2. At Breast Care Center of Florida, providing the highest quality in health care to our patients in an atmosphere of genuine caring is our primary concern. It would be a big help to us if you could let us know what things your insurance requires of you — the subscriber, and us — the provider. With your cooperation and assistance, we will be in a better position to meet our goals of better health care.
3. **Your insurance provider may not cover every service we provide in our office. These disallowed services may include:**
 - Mammograms (know how often your provider will pay for them) (76091)
 - Bone density screenings (do you need precertification?) (76075)
 - Disposable equipment that may be required for your visit/procedure (99070)
4. It is possible that your provider may not cover everything we do, and in these cases, we will have no choice but to bill you for these services provided.

If we cooperate together, each one doing their part, you should be able to receive the benefits offered by your provider, and then we will be able to do what we do best — take care of you.

Please read the following and sign this form.

I understand that my insurance company may disallow and not pay fees related to yearly examinations, bone density screenings, or other services that I receive at this office. If these are disallowed, I understand this office policy. Obviously, this does not include discounts, if any, that we have contractually obligated ourselves to accept from your insurance carrier. In no case will we balance bill you for those discounted charges.

Name: _____ Date: _____

Witness: _____