THE KATHERINE M. CYRAN M.D. BREAST CENTER

Personalized Breast Health, Care, and Imaging

PATIENT INFORMATION - PLEASE PRINT

NAME: _____

Last First MI Name you wished to be called

ADDRESS: _____

Street City State Zip

(____) _____ (____) _____ (____) _____

Home Phone Work Cell

EMAIL ADDRESS: _____

SSN: _____ BIRTH DATE: _____

EMPLOYER: _____ OCCUPATION: _____

PRIMARY CARE OR REFERING PHYSICAN: _____

PRIMARY INSURANCE:

Name of Insurance Company:

_____

Policy Holders Name:

_____

Policy Holder's Birthdate and SS#:

_____

Policy and Group#:

_____

SECONDARY INSURANCE:

Name of Insurance Company:

_____

Policy Holders Name

_____

Policy Holders' Birthdate and SS#

_____

Policy and Group#:

_____

SPOUSE NAME: _____

Last First MI

Spouse Birthdate and SS#:_____

EMERGENCY CONTACT OTHER THAN SPOUSE:

_____

Last Name First MI Relationship to Patient

(____) _____ (____) _____ (____) _____

Home Phone Work Cell

The Katherine M. Cyran M.D. Breast Center **Financial Policy**

Effective 9/14/18

Patient Name/DOB: _____

Thank you for choosing The Katherine M. Cyran M.D. Breast Center as your health care provider. **Please carefully read and initial by each statement and sign below.** This policy has been put in place to ensure that financial payments due are recovered to allow us to continue to provide quality medical care for our patients. It is important that we work together to assure that payment for services is as simple and straightforward as possible. Our practice manager or billing department will be glad to discuss these policies with you.

1. _____ I understand that if I do not have my insurance card, referral, and / or co-payments, that my appointment may be rescheduled until such time that I can provide the required documents or payments.

2. _____ I understand that The Katherine M. Cyran M.D. Breast Center will collect all copayments at the time of visit and any procedure deductibles and coinsurance up to an amount equal to payment in full for the planned procedure code. Payment in full and expected coinsurance payment responsibility are determined by the anticipated billing code(s), details of your insurance policy, and agreement between your insurance company and The Katherine M. Cyran M.D. Breast Center. Any overpayment to your account will be refunded to you after payment and/or remittance has been received from your insurance company.

3. _____ I understand that a $25 service fee will be added for any checks returned for any reason and I will be responsible for payment of this fee and the amount of the returned check. NSF checks must be redeemed with certified funds (cashier's check, money order, or cash.)

4. _____ I understand that if I am unable to make a scheduled appointment I need to contact The Katherine M. Cyran M.D. Breast Center at least 24 hours before my scheduled appointment time. Due to a high demand for appointments, missed appointments prevent us from scheduling appropriately and keep others in need of urgent care from being seen. A $25 FEE WILL BE ASSESSED FOR ALL MISSED APPOINTMENTS & $50 FOR MISSED PROCEDURES NOT CANCELED WITH AT LEAST 24-HOUR ADVANCED NOTICE.

5. _____ I understand that if a payment to my account has not been made within 60 days of a statement date, a 30% fee will be added to the outstanding balance and will be turned over to collections for further processing. No additional appointments will be made for delinquent accounts until they are brought current.

6. _____ The Katherine M. Cyran M.D. Breast Center will allow 60 days from the date of filing for my insurance company to process or pay a claim. State law allows insurance companies operating in the state no more than 60 days to process claims. It is my responsibility to provide my insurance company with requested information needed to process a claim for services. It is also my responsibility to notify The Katherine M. Cyran M.D. Breast Center if there is any change in my insurance coverage, residence, or phone number. ULTIMATELY, IT IS UP TO ME TO KNOW MY INSURANCE BENEFITS.

I have read and agree to all the provisions of the above financial policy. I understand that I am ultimately responsible for all professional fees incurred for professional services performed by the attending physician.

Signature of Responsible Party:_____ Date:_____