Patient Financial Responsibility

Thank you for choosing the HERS Breast Cancer Foundation. We are committed to providing quality DME services to all of our patients. Below is our financial policy for your review and signature:

Filing your Insurance is a courtesy to our patients. We are pleased to assist you by billing to your contracted insurers. However, the patient is required to provide us with the most correct and updated information about their insurance.

If you have a balance, you will receive a statement letting you know the status of your account. Please be aware that some and/or perhaps all, of the products provided may not be covered items from your Insurance. You are also responsible for the payment of **co-pays, co-insurance, deductibles and upgrade fees** not covered by your insurance.

I authorize that HERS Breast Cancer Foundation can release medical and other information acquired to the necessary insurance companies, third party payers and healthcare entities required in processing any payments or reimbursements. I authorize any payments of insurance benefits to be made on my behalf to **HERS Breast Cancer Foundation** for any services rendered to me by HERS Breast Cancer Foundation.

HERS Breast Cancer Foundation will retain this signed and dated payment authorization form in your client file.

Your authorization will allow us to submit your claims electronically from now on without obtaining an additional signature from you.

ACKNOWLEDGMENT OF FINANCIAL RESPONSIBILITY

I fully realize I am responsible for all payments, including any **co-pays, co-insurance, deductibles and upgrade fees** that are not covered by my primary or secondary Benefit Plan.

Printed Client Name: _____

Client Signature_____ Date_____

03-31-2022