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BREAST CARE CENTER

Name
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AUTHORIZATION OF TREATMENT/ASSIGNMENT OF BENEFITS/ RELEASE OF INFORMATION/PRIVACY NOTICE

CONSENT FOR TREATMENT: By this document, I do hereby request and authorize Chico Breast Care Center (CBCC), its medical practices and providers including physicians, technicians, nurses, and other qualified personnel to perform evaluation and treatment services and procedures as may be necessary in accordance with the judgment of the attending medical practitioner(s). I acknowledge that no guarantee can be made by anyone concerning the results of treatments, examinations or procedures.

NOTICE OF PRIVACY PRACTICES: I have received, read, and understand the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information by CBCC. I have had my questions about the Notice of Privacy Practices answered. I understand that CBCC has the right to change its Notice of Privacy Practices from time to time and that I may contact CBCC at any time and request a copy of the Notice of Privacy Practices or may view them at [WEBSITE].

INSURANCE AUTHORIZATION AND ASSIGNMENT: I certify that all information I have provided to CBCC is true and correct. I hereby authorize payment of any medical benefits made on my behalf directly to the CBCC provider of service(s) furnished to me. I authorize and direct CBCC to release any medical information to my health insurance carrier and/or its legitimate agents that is necessary to process related health insurance claims and/or to verify plan benefits in accordance with HIPAA health information standards and the CBCC Notice of Privacy Practices. I hereby assign, transfer and authorize payment of service(s), otherwise payable to me under the terms of my private, group employer's or group health insurance plan, directly to CBCC.

PRE-AUTHORIZATION RESPONSIBILITY: I understand that it is the insurer's responsibility to review anticipated courses of treatment. I understand that if the insurer determines that the treatment plan is necessary and appropriate and Authorizes services, the benefits of my health plan will be available to me according to my policy terms. However, if authorization is denied, benefits may be withheld. I understand that obtaining necessary pre-authorization is the responsibility of the patient, financially responsible party, and/or the referring physician. I also understand that I will be financially responsible for any and all related charges incurred as a result of this treatment plan should the insurer either refuse to pre-authorize the treatment or retrospectively determine that a specific service was inappropriate, or should the authorization occur too late to be valid. I understand that to protect myself from unnecessary personal financial obligations, I must review my obligations with my insurance company and personal physician in advance of my appointment.

FINANCIAL RESPONSIBILITY: I understand that CBCC is acting solely as agent for filing insurance benefits assigned to it; however CBCC assumes no responsibility for guaranteeing payment of covered charges. I understand that my insurance company is being billed as a courtesy to me and that I am financially responsible for charges not covered by the Assignment of Benefits. One such charge may be my patient responsibility as dictated by a deductible, co-insurance, or co-payment responsibility required by my insurance carrier. CBCC may require an up-front payment by me for the estimated patient responsibility. I understand that any amount collected by CBCC from me is considered only an estimate until such time as the claim has been fully processed by my insurance carrier. I agree to make full payment immediately upon receipt of a CBCC billing statement whether it is an interim or final bill. In the event that I fail to make full payment or fail to comply with other payment arrangements made with CBCC's approval, I understand that appropriate collection measures may be initiated.

CONSENT TO ELECTRONIC COMMUNICATIONS (OPTIONAL): By providing my phone numbers and placing my initials on the line below, I understand and agree that CBCC may contact me using automated calls, emails, and text messaging sent to my landline and mobile device. These communications may notify me of preventative care, test results, treatment recommendations, outstanding balances, or any other communications from CBCC related to my healthcare. **I understand that there will be detailed instructions and personal information left on the phone numbers I have provided.** I understand that I may voluntarily "opt-in" to receive automated text message communications from CBCC and its partners by providing my mobile number below, and agreeing to any additional Terms and Conditions established by my mobile carrier. If I agree to receive text messages, I understand I can opt out at any time by replying STOP to the text.

RELEASE OF RESPONSIBILITY FOR PERSONAL VALUABLES: I have been made aware and understand that all CBCC medical practices and offices provide no facilities for safekeeping of valuables. I do hereby release CBCC from any responsibility due to loss or damage of any valuables that I, or anyone accompanying me, may bring to a CBCC medical practice, office or facility.

I, or my legal representative, certify that I have read this document, that it has been fully explained to me and that I understand its contents, and hereby agree to all terms and conditions set forth above and acknowledge the receipt of a copy if requested. I hereby authorize that photocopies of this form to be valid as the original.

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Signature of Patient or Parent/Legal Guardian/Authorized Representative Date