Birmingham Breast Care ♦ Susan B. Winchester, MD ♦ Princess N. Thomas, MD
800 St. Vincent's Drive ♦ North Tower Suite 640 ♦ Birmingham, AL 35205 ♦ (205) 930-0806 ♦ (205) 930-0906 - FAX

Date_____

Patient's Last Name	First	Middle		
Mailing Address		Marital Status	Date of Birth	Age
City	State	Zip Code	Social Security No.	
Home Phone No	Work Phone No	Cell No.	Driver's License No/State	
Patient's E-mail	Race: ❑White ❑Black/African-American ❑Asian ❑Hispanic/Latino ❑Amer Indian/Alaskan Native ❑Native Hawaiian/Pac Islander ❑Other			
Occupation	Employer			
Preferred Pharmacy Name and Location		Pharmacy Phone No.		
Name of Spouse	Spouse's Social Security No.	Spouse's Date of Birth		
Spouse's Work Phone No.	Spouse's Cell Phone No.	Spouse's E-mail		
Spouse's Occupation	Spouse's Employer			
Referred By		Phone No.		

IN CASE OF EMERGENCY NOTIFY (OTHER THAN RESPONSIBLE PARTY)

Name	Home Phone No	Work Phone No.	Relationship to Patient

AUTHORIZATIONS AND ACKNOWLEDGEMENTS

I hereby authorize Susan B. Winchester, MD, PC to discuss my medical and payment information with:

_____	_____	_____	_____	_____	_____
Name (1)	Relationship	Phone Number	Name (2)	Relationship	Phone Number

FINANCIAL AND OFFICE POLICIES

Your clear understanding of our Financial and Office Policies is very important to us. Please read carefully. If you have any questions or concerns regarding the Financial Policy, please do not hesitate to speak to someone in our billing office.

All Patients:

-The patient is primarily responsible for all charges incurred for services and procedures rendered by Susan B. Winchester, MD, PC (Birmingham Breast Care).

-All co-payments, coinsurance, and deductibles are due and payable at the time the service is rendered.

-We accept cash, checks, money orders, Visa, Mastercard, Discover and American Express.

-Changes in healthcare insurance have placed an increased burden on the patient. We participate with Advance Care Card which offers 14 or 6 month *interest free* payment terms for payment of medical expenses. Applying is quick and a response is obtained instantly. Upon approval the Advance Care Card will be delivered to the patient's address in 72 hours. Medical Loans are also available in cases of credit challenges. To apply for medical credit, visit www.advancecarecard.com. The patient must bring the Advance Care Card to the appointment to use for payment of medical services or call our office to make payment on outstanding balances. With this option we hope to remove any financial consideration that might burden and/or compromise the timely diagnosis and treatment of our patients.

-Returned checks will be charged a service fee of $40.

-Balances not paid within 30 days will result in a $15 per month administration fee.

-Delinquent accounts in excess of 90 days will be turned to a collection agency. A collection fee of 33% of the principle balance will be added for collection costs should the account be referred to a collection agency or an attorney for collection plus court costs expended.

-Depending on services provided in our office statements may be received from Susan B. Winchester, MD PC (Birmingham Breast Care), UAB Pathology, UAB Hospital, Cunningham Pathology, St. Vincent's Hospital or Solstas Lab Partners.

-Fees for surgical procedures will vary depending on the service(s) provided. We will assist with pre-certifications if required. Any deductible or co-insurance amount that is the patient's responsibility will be due prior to surgery.

-If the patient does not speak English, it is their responsibility to obtain an interpreter to assist in completing and understanding any documents. This person must be age 18 or over. Initial_____

Uninsured Patients: We collect $150 prior to an initial visit and $75 prior to each follow-up visit. Additional charges for other procedures will be collected at the end of visit.

Form Completion: Disability, Supplemental Insurance Forms, Prior Authorization, and other forms are not required by all insurance plans or employers. If a physician is required to complete these forms, there will be a $30 charge. Claims Forms are $5 per claim.

Surgical Patients: All procedures cancelled or rescheduled within 3 days of the surgery date will be charged a $150.00 non-refundable administration fee. This fee will be waived if surgery is cancelled by a physician.

Medicare Patients: Susan B. Winchester, MD, PC (Birmingham Breast Care) is a participating provider with Medicare. We will submit claims to Medicare and any supplemental insurance. Any remaining balance is the patient's responsibility after payment from insurance and contract adjustments have been made.

Medicaid Patients: All Medicaid patients are required to present a current Medicaid card at every visit. If the Medicaid plan changes, it is the patient's responsibility to make sure we have the correct information for billing purposes. The patient is responsible for obtaining a referral for each visit if one is required. If a claim is denied, the patient is responsible for the fees incurred.

Insured Patients:

-The patient must obtain proper referral and/or authorization if required by their insurance plan prior to the appointment to avoid being held responsible for any charges incurred.

-Your insurance plan is a contract between the patient and their insurance company, even if an employer provides it. We provide the medical service and submit the claim as a courtesy to our patients. We do our best to verify benefits prior to the appointment to make sure we collect the appropriate amount owed and to make sure the visit will be covered by the insurance plan. Birmingham Breast Care cannot know all the details of every plan. Ultimately, the patient is responsible for knowing what services are covered, how often, and how much of the cost is patient responsibility. The patient is responsible for services that insurance does not cover such as co-pays, deductibles, co-insurance and anything else that the plan determines is patient responsibility. We are required to collect co-pays, deductibles and co-insurance per our contracts with insurance carriers. These amounts cannot be negotiated or waived.

-We DO NOT balance bill patients. We abide by all contractual write-offs from insurance. Patient responsibility is ONLY that as directed by the insurance company.

-The patient is required to provide the most current insurance information, including a copy of the insurance card and any changes in the insurance plan coverage.

-We allow 60 days from the date the claim is filed for insurance to pay. It is the patient's responsibility to ensure their insurance plan pays in a timely manner. If no payment has been received from the insurance company after the 60 day grace period, the patient will be billed for the balance.

Account Statements: Account Statements are posted to our patient portal (YourHealthFile.com) which may be accessed from www.birminghambreastcare.com. **Please ask the front office staff for a dedicated user id and password.** Once access is set up email notification is sent when a new account statement is generated. Payments can be made directly through the Patient Portal and/or our website.

Acknowledgement:

-I acknowledge that a copy of Susan B. Winchester, MD's Notice of Privacy Practices has been made available to me.

-I authorize the release of any medical information necessary to process a claim on my insurance policy(ies). I hereby assign and authorize payment directly to the office of Susan B. Winchester, MD all benefits payable under such insurance policy. I agree to pay the remaining balance including amounts not covered by insurance. I agree to waive my rights of exemption as to personal property in the case of collections. I understand that no oral or written contract exists which designates by name or description the individual who will treat the patient.

-I consent to receive calls, individual or automated, from Birmingham Breast Care and/or its authorized affiliates for my protected healthcare and any other services at any phone number(s) provided, including any wireless numbers. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

-I understand that my insurance policy may require a copay, deductible and/or coinsurance that applies to my medical visit today and there may be post-visit patient responsibility. I understand and acknowledge all policies indicated above. The authorizations and acknowledgements will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as an original.

Signature:_____ Date _____

Patient Name:_____ Date of Birth:_____ Phone:_____

Email address:_____