BREAST CARE FOR Washington DC
QUALITY. CARE. COMMUNITY.

Patient Financial Responsibility Form

I, _____, the undersigned, realize that I am financially responsible for all services rendered to me by Breast Care for Washington or Services rendered to me under the direction of Dr. Regina Hampton, Medical Director or Dr. Martha Garrison, Lead Radiologist.

Check one or more of the following:

☐ Breast Care for Washington will bill my insurance company. I understand that I am responsible for any co-pays or deductibles for my exam.

☐ Breast Care for Washington does not participate with my insurance plan. By choosing an out-of-network facility or physician I will be responsible for payment of all charges that are not paid by my insurance company.

☐ I do not want my insurance company billed. I will be responsible for payment of all services provided.

☐ I have an "opt-out" or out of network benefits and will be responsible for payment of charges not covered by my insurance company.

☐ I understand that I do not meet eligibility criteria for any of BCW's financial assistance plans and that I have been offered a sliding scale fee for my exam(s) for which I am responsible.

Patient Name _____
(Please print)

Patient or Parent/Guardian _____ Date _____
(Signature)

Witness_____ Patient Account # _____