

DEBORAH O'CONNELL, M.D.
WOMEN'S IMAGING CENTER



Notice of Coverage

At the Deborah O'Connell Women's Imaging Center, we appreciate and value our patients. Our goal is to provide a quality healthcare experience, including how we handle managed care and billing issues.

Health insurance is a contract between you and your insurance company. You are responsible for your account. Disputes with your insurance company must be resolved by you and does not alter your direct responsibility for medical bills. We will do what we can to help you understand your benefits, but insurance matters are ultimately your responsibility. If you need prior authorization for your insurance, it will be up to you to let us know if we need to make any calls to help with this. **It is also your responsibility to know if deductibles have been met, visits allowed per year, the amount that is reimbursable by your insurance company, and any other plan specifics.** Regarding overdue accounts, if your account has not been paid for more than 60 days and a payment schedule has not been arranged with us, the use of a collection agency or other legal action may become necessary in addition to a late fee of 10% of the account balance.

If you receive a statement from The Deborah O'Connell Women's Imaging Center stating that you owe something different than what you expected, please contact our billing office at 281-359-7788 and they will gladly assist you.

Assignment of Benefits

I hereby authorize payment of all health insurance benefits to The **Deborah O'Connell Women's Imaging Center** and allow assignee to release all information necessary to secure payment. I agree that a photocopy of this authorization shall be considered as effective and valid as the original. I understand that I am legally responsible for all charges incurred whether or not they are paid by said insurance and that any unpaid balance shall be due in full IMMEDIATELY, 45 days after my date of service. I will remit any payment made to me directly by my insurance carrier for services billed by **The Deborah O'Connell Women's Imaging Center**. I understand that I am financially responsible to **The Deborah O'Connell Women's Imaging Center** for charges not covered by this Assignment of Benefits. I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to procedure.

Patient or Parent/Guardian Signature: _____ Date: _____

Release Information

I hereby authorize **The Deborah O'Connell Women's Imaging Center** to furnish medical information concerning my present illness or injury to my family physician(s), referring physician(s), and insurance companies. I further authorize my family physician(s), referring physician(s), and other healthcare providers to furnish all medical information concerning my present illness or injury to **The Deborah O'Connell Women's Imaging Center**.

I authorize the release of any necessary medical information to **The Deborah O'Connell Women's Imaging Center** to assist in my diagnosis. I have read, understood, and hereby consent to the examination and the above conditions. _____

Acknowledgement

I, _____ (patient name), acknowledge that I have received a copy of **The Deborah O'Connell Women's Imaging Center** Notice of Privacy Practices.

Patient or Parent/Guardian Signature: _____ Date: _____

Patient Name: _____

DOB: _____

Please send mammograms and breast imaging to:

Deborah O'Connell Women's Imaging Center
2200 Park Bend Drive, Building 2, Suite 301
Austin, TX 78758