INSURANCE INFORMATION: *The receptionist will make a copy of your insurance card.*

FINANCIAL POLICY – PAYMENT ARRANGEMENTS AND MEDICAL INSURANCE:
We are committed to provide you the best possible care. If you have medical insurance that we do file for, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy. Payment for services is due at the time services are rendered (co-pays where applicable). We accept cash, checks, money or credit cards for your convenience. Returned checks and balances older than 30 days may be subject to additional collection fees. We appreciate you notifying our office should the need arise to cancel your appointment. A fee could be charged for each time that you are a "no show" for your appointment. This fee will not be filed with your insurance company.

We will gladly try to help with questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowable determined by each carrier.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select services they will not cover. We may ask you to say a statement informing you of your financial responsibility if one of these services apply to you.

We must emphasize as medical care providers, our relationship is with you, not your insurance company. While the filing of some insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. I have read and understand the above mentioned Financial Policy.

X_____ _____
Patient or Responsible Other Signature Date:

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN AND TO RELEASE INFORMATION:
I authorize the release of payment of all medical benefits for services rendered by Dr. John Carter to him directly. I realize I am responsible to pay all non-covered services, and in consideration of furnishing of medical and related services, hereby guarantee payment in full in 30 days or as otherwise arranged. I also authorize the Physician to release any information for the purpose of validating and determining benefits form any insurance carrier.

X_____ _____
Patient or Responsible Other Signature Date:

NAMES OF FAMILY OR OTHER PERSONS WE MAY DISCUSS YOUR MEDICAL CONDITION:

X_____

MEDICARE RECIPIENTS ONLY:
I request that payment of authorized Medicare benefits be made only on my behalf for services furnished to me by Dr. John Carter including physician services. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits for related services.

X_____ _____
Patient or Responsible Other Signature Date

ACKNOWLEDGEMENT OF OPPORTUNITY TO RECEIVE AND REVIEW DR. JOHN W. CARTER'S NOTICE OF PRIVACY PRACTICES:
By my signature below, I am acknowledging the following:

☐ have received and/or reviewed Dr. John W. Carter's Notice of Privacy Practices

☐ have been offered but do not wish to receive and/or review Dr. John W. Carter's Notice of Privacy Practices. I understand that I may request a copy of the Notice at any time.

X_____ _____
Patient's Signature Date

X_____ _____
Legal Guardian, Guarantor, or Responsible Party's Signature Date

X_____ _____
Witness to Signatures Only Date