INSURANCE POLICY AND ASSIGNMENT OF BENEFITS

We are participating health care providers for many PPO's, HMO's, Points of Service (POS) and other Insurance carriers and plans.

We hope that you are already familiar with your Insurance policy (deductibles, co payments, covered and non covered expenses and prior authorization requirements). We recommend that you contact your Insurance Company if you are not sure of your coverage. If you wish to have us bill your insurance for you, we MUST have a copy of your Insurance card. If you do not have this information with you, we ask that you pay the initial office visit in full. We will then give you the necessary information for you to bill your insurance and you may give us your insurance information at the next visit.

Regardless of your plan, you will need to pay for **DEDUCTIBLES, CO PAYS** and **NON COVERED** services at the time of your visit.

We will do everything possible to facilitate prompt reimbursement by your Insurance company.

PLEASE SIGN BELOW: I authorize payment of benefits through my insurance carrier to be paid directly to **GARY S. MCCARTER, D.P.M.** I realize that I am still responsible for any **DEDUCTIBLES, CO-PAYMENTS** and all **NON-COVERED** expenses. I also authorize Dr. McCarter to furnish my insurance company with my medical records describing his treatment.

I understand that my Insurance will be billed as a courtesy and if they have not responded to the claim within 90 days, it will be my responsibility to pay the doctor and follow-up on my own with my insurance company.
ALL BILLS ARE TO BE PAID IN FULL IN 90 DAYS (3 MONTHS)

Patient Signature Patient Name Date

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____

Patient Name **Patient Signature**

_____

Parent or Authorized Representative (if applicable)

_____

Date