21 Upper Ragsdale Drive
Suite 100
Monterey, CA 93940
(831) 648-8020

Patient Financial Responsibility Form

We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

I understand you will bill my medical insurance as a courtesy. Therefore I authorize payment directly to Jeffrey D. Carter M.D. I also authorize the doctor & staff to release any required information to secure payment for services rendered to me or to my dependents.

I understand it is my responsibility to know & understand my medical coverage. I will pay my co-payment at the time of service. Co-Insurance, Deductibles and non-covered services are due within 30 days from date of receipt. If payment is not received, I understand my account will go to a collection agency unless prior financial arrangements have been made.

If no medical insurance will be billed, I understand full payment of today's services will be required at the time I check out.

I understand there is a minimum charge of $25 for any forms that need to be filled out. (Disability forms, DMV forms, FMLA forms, Etc...)

I understand that your office is <u>not</u> responsible for mailing or faxing any forms. I am responsible to pick-up forms to ensure proper delivery.

I understand that your office is HIPPA complaint and I may receive a copy of the Private Policy Practice if I should request one.

We are <u>no</u> longer taking the "Covered California Exchange Program" through Anthem Blue Cross.

Signature of responsible party: ______________________________ Date: ___________

***Please list any names, parties, or related persons you are authorizing to communicate with Dr. Carter and staff regarding your care and medical information.

____________________________________ Relation ________________________