Authorization and Release/ Financial Agreement

All patients or guarantors (if patient is a minor) are responsible for the full Payment for services rendered by their physician and physician practice group. By Signing this agreement, you agree to pay at the regular rates and terms of Dr. John C. Carter and/or any remaining balance due after my insurance company does not pay. I authorize and request that my insurance company remits payments directly to Dr. John C. Carter. I authorize Dr. John C. Carter to release the diagnosis, records and any other information pertaining to the treatment or exam to a third party payer and/or health practitioner. I realize if I give incorrect insurance or no insurance information that I will be responsible for submitting to my insurance company on my own if it is more than 30 days after my date of service.

I understand scheduled appointments that I do not appear for and I have not cancelled with Dr. John C. Carter within 24 hours prior to the appointment date and time will be considered a "No Show". I understand a $25.00 charge will be added to my account for each occurrence. I understand any balance over 30 days will be assessed a $25.00 late fee per month regardless of amount of balance until balance is paid in full. Unless an agreed upon payment is made on time each month. This fee is on top of monthly finance charges all accounts are charged whether payments are being made or not.

In the event that the account becomes delinquent (balance still due more than 60 days from the date(s) of service), a finance charge of 18% annually (or 1.5% per month) will be added to your account. In addition, in the event the account is turned over to a collection attorney, you agree that you will be responsible for an attorney fee equal to 35% of the outstanding balance due on the date the account is turned over for collection.

Payment Options

We are in network with Delta Dental, Anthem, and Metlife. We will submit to all insurance companies other than Medicare and Medicaid. We do accept Cash, Visa, Master Card, and Care Credit as payment for treatment. Depending upon your balance with our office we will consider allowing you to pay the amount due in equal installments over a 90-day period. This payment option will require a signed financial agreement and a copy of your card to automatically debit the amount we agree on each month. We are able to run your information through Care Credit for approval. This option will allow you to pay the amount due over a greater period of time. (Note: interest charges may be applied)

My signature below represents that I have read and understood these policies and payment options of Dr. John C. Carter. I agree to make information available required and necessary for any insurance claims to be filed by Dr. John C. Carter.

Patient's Name (print)_____ date_____

Guarantor's Name (print)_____ date_____

Patient's Signature _____ date_____

Witnessed By_____ date_____