Insurance Waiver

1. INDIVIDUAL'S RESPONSIBILITY FOR NON-COVERED SERVICES:
In consideration of services rendered by William Purtill, M.D, PC to the Undersigned patient, the undersigned promise(s) to pay William Purtill, M.D, PC any co-payment, coinsurance or other charges required to be paid by my health insurance coverage.

11. ASSIGNMENT OF BENEFIT PROCEEDS
I request that payment of authorized HMO/third-party payor/governmental agencies (Medicare and Medicaid) benefits be made either to me or on my behalf to William Purtill, M.D., PC for services furnished to me by the provider.

Medicare Patients: Upon receipt of the Medicare Explanation of Benefits, we will bill you for the difference between what Medicare has paid us and the amount Medicare legally allows us to charge you. We will bill your secondary insurance, if you have one. ACCEPTED ASSIGNMENT DOES NOT EXEMPT YOU FROM PAYMENT OF THE BALANCE DUE.

111. AUTHORIZATION TO RELEASE RECORDS:
I hereby authorize William Purtill, M.D., PC to release to my insurer/HMO/third party payor, governmental agencies, or to whomever is financially responsible for my medical care, all information needed to substantiate payment for such medical care and, if required, for recertification/prior approval purposes.

1V. REFERRALS/CO-PAYMENTS:
HMO PLANS (HIP, GHI, CIGNA, ETC.): For plans requiring Referrals from the primary care physician, AUTHORIZATION MUST BE OBTAINED PRIOR TO THE TIME OF THE VISIT. Unauthorized visits will be billed to you according to the regular fee schedule. CO-PAYMENTS ARE DUE AT THE TIME OF VISIT. If benefits are denied due to lapsed coverage, You will be billed according to the regular fee schedule.
Private Insurance: PAYMENT IS EXPECTED AT THE TIME OF VISIT.

PRIVACY NOTICE ACKNOWLEDGEMENT

V. I acknowledge that I have been provided with a copy of William Purtill, M.D, PC's Privacy Notice.

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Signature of Patient or Authorized Representative Date