GARRETT H. BENNETT, M.D., P.C.
Sinus and Nasal Surgery
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(212) 980-2600
Fax: (212) 991-3009

PATIENT INSURANCE COVERAGE AGREEMENT

Name _____

We have verified your commercial insurance and would like to make sure you fully understand your benefits. Please take a moment to review the following information:

We will be billing your insurance carrier for your office visit. Please be aware that your insurance may send Dr. Bennett's reimbursement check directly to you for the care and services you received from him. Please note, that the check will be issued in the name of the insured; however, the monies contained in the check are the payment to Dr. Bennett for his services. When you receive these checks please endorse them by signing the back and writing "pay to the order of Dr. Garrett Bennett" beneath your signature. Please send the check, along with the attached "Explanation of Benefits", to our office.

All checks and EOB's must be submitted to the office within 2 weeks of issue date or we reserve the right to bill your credit card **in full** for the services provided.

If you have any questions regarding billing please contact: Paul at VGA Billing Services:
212-206-6465.

***We require a credit card on file because the reimbursement checks may come to you.**

Card Type: Visa MasterCard American Express **Security Code: _____

Card#: _____ Exp.: _____

I have read and understood this agreement.

Patient Signature: _____ **Date:** _____