

Heather N. McCombs, DPM LLC  
980 N Michigan Ave, Suite 1100  
Chicago, IL 60611  
312-944-0000 T 312-944-0007 F

## PATIENT RIGHTS AND RESPONSIBILITIES

### INSURANCE BENEFITS

I understand that I am responsible for knowing my insurance benefits  
I acknowledge that Heather N. McCombs, DPM LLC is not responsible for providing benefit information to me, ultimately I am responsible for knowing benefits. Any information provided by the office of Heather N. McCombs, DPM LLC is not a guarantee of benefits.

### INSURANCE CLAIM SUBMISSION

Heather N. McCombs, DPM LLC will submit medical claims to your **Primary Insurance Carriers**.  
Heather N. McCombs, DPM LLC will submit medical claims to **Secondary Insurance Carriers** if this information is provided to our office.

### PATIENT BALANCE

Heather N. McCombs, DPM LLC sends monthly statements to all patients with outstanding balances.

As a patient of Dr. McCombs I understand that I am responsible for payment of services provided. In this capacity I hereby authorize to remain effective until I submit in writing to the contrary.

Submit insurance claims on my behalf and to accept payment of benefits for services rendered.

To initiate a complaint to my insurance company and or the Insurance Commissioner on behalf of resolving my claim.

The release of medical information to my insurance company, adjuster, or attorney involved in the processing of my claims.

Should the insurance company remit payment in my name for services rendered by Heather N. McCombs, DPM LLC, I authorize Heather N. McCombs, DPM LLC to deposit that payment and credit my account.

I am aware that Heather N. McCombs, DPM LLC accepts Medicare and certain PPO assignments, I am responsible for co-pay amount, co-insurance, deductible and any non-covered or cosmetic services, as deemed "patient responsibility" by my insurance company.  
Heather N. McCombs, DPM LLC does not participate in IDPA, Unicare, or any HMO plans.

I acknowledge that I am responsible for a \$25.00 service fee for NSF checks.

I acknowledge that my account balance will increase by 25% if my account is turned over to a collection agency, to cover the fees of collection.

I acknowledge that I will be billed a \$25.00 charge for missed appointments or appointments not cancelled by 4:30pm the business day prior to my scheduled appointment.

---

Signature

Print Name

Date