GNÔRTH

PRACTICE FINANCIAL POLICY

As a courtesy, if you have medical insurance, we are happy to file your claim on your behalf and help you receive your allowable benefits. In order to do this, we need your assistance and understanding of our financial policy. You are financially responsible for certain charges at the time of each office visit or procedure. You may be responsible for any, or all, of the following:

Co-Payments: This is a set dollar amount that you are required to pay at each office visit. Based on your individual contract with your insurance, your plan may require that you pay a portion of the discounted amount they pay us at the time services are rendered to you. This amount is called your co-payment. It is not our policy to bill you for your co-payment, as this further increases our expenses and is also in violation with your care plan requirements. If you are unable to pay your co-pay at the time of service, a **$25.00** fee will be charged in addition to your co-pay amount.

Deductible: Some plans require that you pay a certain amount before your insurance company will cover any medical expense. This deductible is your patient responsibility based on your plan.

Co-Insurance: This is a percentage of charges that you pay according to your individual plan.

Patient Payment Responsibilities or Non-Covered Services: In some cases, your insurance may not cover certain services or may have coverage limits in place. Limited coverage on routine, preventive healthcare is common among insurance plans. Not all services are a covered benefit in all contracts. Some insurance companies select certain services they consider medically unnecessary. For this reason, we can provide you a form letter to complete by contracting your insurance plan and verifying the specific coverage you have prior to a procedure or visit. We will make every effort to ascertain your coverage for our services before treatment. However, this does not guarantee payment from your insurance carrier. We may request payment for any known, non-covered services at the time of your visit. A payment arrangement can be established with our Billing Department.

Payment for Service: If co-payments, coinsurances and/or deductibles are required by your insurance plan, they are due when services are rendered. The balance on your statement is due and payable when the first statement is issued and is considered past due if not paid within **30** days. A Statement Fee will be implemented at the rate of **$5.00** for each additional statement that is sent with no payment received.

Self-Pay Patients: Patients who have no insurance are asked to pay in full at the time of service. If for any reason you may be unable to pay in full at the time of service, speak with the Billing Department in advance of your visit to determine if a payment arrangement can be established.

Procedure Charges: If a procedure is scheduled, we will file your insurance claim and accept assignment on your behalf, however, you will be responsible for payment of any deductible, coinsurance and non-covered charges prior to the procedure. If the determined deductible has not been paid within **7** days prior to procedure, the procedure may be cancelled or rescheduled until payment is received.

Patient Initials: _____

Returned Checks: There is a **$35.00** fee for any checks returned by the bank. If your check is returned by the bank, we will no longer accept checks from you for payment. We will accept only Cash, Visa, Mastercard or Discover cards.

Cancellations/Missed Appointments/Re-Scheduled Appointments: We have reserved examination space, medical personnel, medical equipment and medical supplies for your visit. Therefore, a **24**-hour notice is required for cancelled office appointments to avoid a **$50.00** Late Cancellation/No Show fee. A **72**-hour notice is required for cancelled and/or rescheduled procedures to avoid a $**300.00** Late Cancellation/No Show fee. These fees are not covered by your insurance and will be your responsibility to pay.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. You will receive the first statement to notify you of your account balance after the last service you received. If no payment is received within **30** days of time of service a Statement Fee of **$5.00** will be implemented. This will be applied to your account balance for each additional statement that is sent with no payment received. Accounts that are unpaid for over **90** days will be placed with a collection agency. A **25%** balance fee increase will be added to cover the cost of the collection agency. You will be responsible for any collection fees, cost and interest and/or attorney fees applied to unpaid account balance. On accounts that payment arrangements have been made and have been defaulted, clinic services will no longer be provided until account is paid in full.

Medical Records/Medical Forms: Medical Records remain in the custody and control of our office. Upon written consent, copies can be made and supplied to you or to whom you designate. You authorize us to include all information including your billing and payment history. Our office charges for the copying of medical records according to Georgia State Law guidelines. Before the processing of any medical form such as FMLA and/or Short Term Disability, a **$25.00** fee is required.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. We will allow you **30** days or setup of a payment arrangement to pay any balance remaining after insurance payment. If you have any questions about the information or any uncertainty regarding your insurance coverage, please do not hesitate to ask us. We are here to help you.

PLEASE READ THE ABOVE CAREFULLY BEFORE SIGNING.

By signing below, I acknowledge that I have read and understand this policy:

Signature: _____ Date: _____

(Patient and/or Responsible Party)

Patient Initials: _____