Statement of Financial Policy

It is our firm belief that all patients who come to this office expect and deserve quality medical care. In order for us to provide this level of service, it is important that our patients understand our financial policies. Therefore, we are asking that you read and sign the following important information:

1. If we are a participating provider in your plan, we will be listed in your group's "provider list" or "preferred provider" directory. This is not a guarantee of payment. We will bill your insurance company directly and receive payment from them directly. Most plans require a "co-payment" per visit and/or have yearly "deductibles". Some plans require you to pay a 20% co-payment when diagnostic tests are provided. We require that co-payments and/or deductibles be paid prior to services being rendered or the appointment can either be rescheduled or patient may have an additional $25.00 added to their account.

2. If your insurance requires referral approval, necessary documentation is your responsibility. You must give your referral form and/or number to the receptionist when you check in to see the doctor. Failure to comply with the requirements of your insurance company could leave you responsible for services rendered.

3. If your insurance information is up-to-date, we will file up to two separate insurance claim forms for services you receive. It is your responsibility to tell us about changes in your insurance plan. It is important to remember that your insurance coverage is a contract between you and your insurance company. Although we file claims for you, you are still responsible for your bill, regardless of the amount your insurance company pays, except in cases of pre-negotiated insurance agreements and where legally prohibited.

4. If you do not have insurance, payment is expected at the time you receive services. Payment will be accepted in cash, by check or credit card. If check is returned for non-sufficient funds, an additional service fee of $30.00 will be added to the patient's account. If payment in full is not possible at the time of service, arrangements must be made through our billing office.

5. In the event that payment is not received after 3 payment notifications have been mailed, a 25% collection fee will be added to the account prior to being submitted to the collection agency. It is the responsibility of the patient to notify the office of any insurance, address or other demographic changes.

6. In order to assist patient requests for an immediate appointment, we require at least 48 hour advance notice should your appointment need to be cancelled or rescheduled. If you do not provide us notice at least 48 hour advance notice a $25 charge may be added to your account.

We hope this Statement of Financial Policy helps you understand the importance of prompt payment of your bill. Please feel free to call our billing office at (912)354-4813 if you have any questions.

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I have read the above information and understand that I am responsible for notification for notification of my insurance plan mandates.

Patient / Guarantor's Signature Date

Patient's Name Patient's Date of Birth