Atlanta Women's Healthcare Specialists, LLC

275 Collier Road, NW Atlanta, Georgia 30309

FINANCIAL POLICY

Patient Name:_____

(Please print)

Atlanta Women's Healthcare Specialists' providers are committed to meeting your health care needs! We are pleased that you have chosen us! Listed below are our financial policies. If you have any questions, please discuss them with our financial team.

Patient Responsibility

1. All co-payments are due at the time of visit. Post dated checks are not accepted.
2. Co-insurance and unmet deductibles are due prior to scheduled office visits, ultrasounds, surgeries, and procedures. Once benefits are verified and your financial responsibility calculated, you will be notified of the payment amount and due date.
3. You are ultimately responsible for payment of charges for services you receive from our office.
4. In accordance with your insurance member handbook, it is your responsibility to provide accurate insurance information and to present your insurance ID card at the time of your visit. If you do not have insurance or do not present a valid insurance card, you will be responsible for payment at the time of service. We will provide you with a copy of our billing form so that you can obtain reimbursement from your insurance company.
5. It is your responsibility to ensure that our physicians are in your insurance network.
6. If your plan requires a referral, it is your responsibility to obtain this prior to being seen by our provider.
7. It is your responsibility to notify the office of any change in your mailing address and phone number(s).
8. Cancellations for appointments and procedures must be received at least 24 hours prior to the scheduled appointment. Cancellations for scheduled surgery must be received at least 5 days prior to the scheduled surgery date and time.
9. Payment is due for rendered services 7 days from receipt of your billing statement. Unpaid previous balances must be paid in full prior to any additional visit unless arrangements have been made with our financial counselor.

Fees

1. The returned check fee is $30.00.
2. There will be an additional charge of 25% of the balance owed for any past due balance that is submitted to an outside agency for collections.
3. Patients who fail to keep and fail to cancel a scheduled appointment may be charged a $50.00 No Show Fee. There is a $200.00 cancellation fee for scheduled surgeries that are cancelled less than 5 business days from the date and time of surgery unless cancellation is due to insurance denial or medical necessity.
4. Medical records requests must be received in writing at least 72 hours prior to the date needed. Fees for medical records are set in accordance with allowable amounts as defined by the State of Georgia. Fees must be received prior to record delivery. No more than 5 pages may be faxed. *We strongly discourage faxing medical records unless the recipient has a dedicated and personal fax for delivery.*
5. When a physician treats you via telephone after hours it is for emergencies only. Therefore, for routine problems that require history, diagnosis, and treatment (i.e., calling a prescription or refill into a pharmacy), the provider **may** bill a $50 or $75 service fee. There is no charge for labor related calls, OB problems, and emergent medical issues.

Administrative Services

There is a fee for patient Administrative Services. Our office collects an **OPTIONAL** Administrative Service Fee of $5.00 per office visit for Gynecologic visits and $75.00 per pregnancy for Obstetrical visits (payable at the beginning of the Prenatal Care) which covers **all** forms that need to be completed during your pregnancy. **YOU ARE NOT REQUIRED TO PAY THIS FEE;** however, if you choose not to pay the fee there is a $20.00 charge for **each** required Administrative Service payable prior to service completion.

This Administrative Service Fee covers specific administrative services such as forms completion for family medical leave and disability, letters for insurance authorizations for brand or non-formulary drugs, letters for employers, school, health clubs, and any other administrative item not covered by insurance.

_____ (Initial) **I accept the Administrative Service Fee. I will pay $5.00 per visit. (GYN)**

_____ (Initial) **I accept the Administrative Service Fee. I will pay $75.00 today. (OB per pregnancy)**

_____ (Initial) **I decline the Administrative Service Fee. By declining the Administrative Service Fee, I understand that I will be charged $20.00 for each Administrative Service requested.**

My signature authorizes Atlanta Women's Healthcare Specialists, LLC, to file insurance claims on my behalf to Medicare or other insurance plans and for payments of any benefits due under my insurance plan to be made to Atlanta Women's Healthcare Specialist, LLC when insurance is filed on my behalf.

By my signature below, I acknowledge that I have read and understand this Financial Policy.

Patient Signature _____ Date _____