INTERNAL MEDICINE
SPECIALISTS OF ATLANTA, P.C.

FINANCIAL POLICY

Listed below are our financial policies. If you have any questions, please discuss them with our financial representative.

PATIENT RESPONSIBILITY

1- All co-payments are due at the time of visit.
2- Co-insurance and unmet deductibles are your responsibility.
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. Any charges which are accrued because of failure of notification will be the responsibility of the patient. If we cannot verify insurance, you will be responsible for payment at the time of service.
5- It is your responsibility to ensure that our physicians are in your insurance network.
6- Cancellations must be received 3 business days in advance for a physical and 1 business day prior to an office visit to prevent the fees outlined below.
7- Payment is due for rendered services 15 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- Failure to cancel or keep an appointment for an office visit will result in a $50.00 fee and $150.00 if the appointment is for a physical.
3- Medical records requests must be received in writing at least 5 days 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.
4- There is a $15.00 fee for completion of documents such as FMLA and insurance forms, or any other paperwork which require time away from patient care for our doctors. Please allow 5 business days for completion.
5- All outstanding balances will be subject to a 12% APR finance charge.

MEDICAID

Our practice does not participate.

Patient's name (print): _____ **Date of birth:** _____

Patient's signature: _____ **Date:** _____

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