6300 Hospital Pkwy., Suite 375 Johns Creek, GA 30097
4040 Old Milton Pkwy., Suite 200, Alpharetta, GA 30005
Phone: 770-771-5270 Fax: 770-771-5279

Financial Policy

We hope to make your visits in our office as thorough and pleasant as possible. We also want you to have a full understanding of our financial policies and expectations for payment and services. Please carefully review and sign our financial policy, and let us know of any questions you may have.

The primary and final relationship is between the Physician and you (the Patient). Our contract is with you only. We will not compromise you medical care to satisfy ANY insurance company. Please bear in that insurance is meant to help defray the cost of medical care and is NOT intended to dictate you treatment.

Payment is due in full at the time services are rendered. This includes deductibles, co-payments, co-insurances and non-covered services.

As a courtesy, we are happy to assist you in the filing of most insurance claims and completing insurance forms and insurance precertification. You will be responsible for any and all balances not covered by your insurance. If your insurance has not paid their portion within 60 days of being property billed, the entire balance will be your responsibility. The ULTIMATE RESPONSIBILITY for the filling and processing of claims to satisfy your insurance carrier REMAINS WITH YOU. If you are unsure of any specific requirements of you insurance, PLEASE ASK THEM. As the insured client, you are in the best position to follow up with your insurance carrier to ensure payment is being processed. It is your responsibility to inform us in cases of any change of your insurance or policy type, failure to do so results in you being responsible for the amount.

You will receive a monthly statement requesting payment of any unpaid balance. If your account becomes past due, please contact our office to discuss payment arrangements and avoid further collection efforts. We are committed to being sensitive to patient financial difficulties, but are unable to assist if you do not contact us to discuss your account. Nonpayment will result your account turned to collection agency and discharge from the practice. You will be responsible for collection charges born by collection agency on top of the amount due from North Atlanta Women's Care PC.

There is a fee (currently $35) for any checks returned by the bank. **Appointments and procedures not cancelled with 24 hours notice may result in charges for time reserved. This will be billed directly to you and will involve a standard fee of $25 for appointments and $250 for procedures.**

There is a Flat Fee (currently $50) for any medical record you request from our office. There is also a required payment of $30.00 for the completion of EACH set of short-term disability forms, leave of absence and/or Family Medical Leave Act (FMLA) forms.

We are here to serve your health needs and will work hard on your behalf, to contain fees and other charges while delivering quality health care to you.

I have read and understood the above policies. I understand that I may receive a copy of this form upon request.

Patient Name_____ Date_____/_____/_____

Signature of Patient or Responsible Party _____