Financial Policy

Patient Name_____ **Account #**_____

We are committed to meeting your healthcare needs. Our goal is to keep your insurance or other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner, we ask that you please adhere to the following guidelines:

1. **You** are ultimately responsible for payment of charges for services you receive from our office. **$25.00** will be added to your account for any checks returned to our facility.
2. It is **your** responsibility to provide us with your current address, telephone number, and insurance information at **each visit**.
3. It is **your** responsibility to contact your insurance carrier to confirm that our physicians participate on your plan. **You** will be responsible for full payment if you see a doctor who is not currently on your plan.
4. If your plan requires a referral, it is **your** responsibility as the patient to obtain this **prior** to being seen by our physicians. Please notify the office **72 hours** prior to your appointment if we are required to obtain the referral for you.
5. Co-pays are due at **time of service.** A **$25.00** service fee will be added to your account for failure to pay.
6. Laboratory services may be provided by a contracted outside reference lab (ie. Lab Corp, Quest, etc.) Lab charges **not covered** by your medical insurance will be billed to you by the independent lab service. **You** accept responsibility for these charges.
7. **ALL** medical record requests must be in writing and received in our office **72 hours** prior to when the data is needed. Records that exceed **10 pages** will be mailed, not faxed. If you require the records for anything other than "continuity of care" there will be a fee for processing the request. The usual fee range for this service is **$10-$50.00,** depending on the number of pages.

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Patient Signature *Date*

Atlanta Women's Health Group, P.C.

Administrative Service Fees (ASF)

Once a year, our offices offer an **optional** Administrative Service Fee. The cost per year is **$15.00** for Gynecological patients (not pregnant) and **$75.00** for Obstetrical (pregnant) patients. This fee would provide unlimited use of services, no matter how many times you call or visit the office within the year. You are **not required** to pay the ASF; however, if you choose not to pay the optional fee you will be charged for non-covered administrative services as needed. **A list of our administrative services with associated fees is found below.**

Services you are responsible for paying on an as-needed and/or requested basis include, but are not limited to:

1. Completion of all patient-requested forms, letters and/or documents requiring the physician's signature. This also includes administrative forms requested by third parties (excluding your insurance company and/or another physician). Said forms will be provided to you at a cost of **$75.00** per form.

   Examples of forms that **you the patient** may request us to complete and provide are:
   A. School
   B. Adoptions
   C. Camp
   D. Foreign Travel
   E. FMLA (Family Medical Leave Act)
   F. Short Term Disability
   It is standard for most employers to require (1) or more disability forms to be completed prior to taking maternity leave.

2. Computer-generated reports (claims, statements, payment history, etc.) that you request will be charged up to **$15.00** per report provided. These reports are sometimes needed for flex benefit plans and/or yearly tax purposes.
3. The Administrative Services Fees **does not** include copying and forwarding of Medical Records.

( ) I accept the Financial Policy, but **do not** wish to pay the Administrative Service Fees.

( ) **GYN Patient:** I accept the Administrative Services Fees at the cost of **$15.00**. This service will be effective for a 12-month period from the date signed.

( ) **OB Patient:** I accept the Administrative Services Fees at the cost of **$75.00** (payable before the 7th month of pregnancy). This service will be effective for a 12-month period from the date signed.

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Patient Signature *Date*