

Office Financial Policy

325 Hammond Drive, Suite 201
Atlanta, GA 30328
(404)-256-0114

RESPONSIBILITY OF BILL

I, _____, (referred to hereafter as "the undersigned") agree and understand that payment for any treatment/therapy/massage is due at the time of service, unless previous arrangements have been made. The undersigned hereby accepts full financial responsibility for charges and services rendered. I also agree that this obligation shall exist regardless of private contractual agreement between the undersigned and any insurance carrier, attorney, or third party not signing this agreement. Financial responsibility will also include charges for services not covered by insurance or for which payment is denied through any utilization review or pre-certification procedures. I also understand that if I suspend or terminate my care or treatment, the fees for services already rendered to me will be immediately due and payable. In the event of my payment default I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required for collection. I understand that this policy applies if I am signing for a minor and/or dependent.

INSURANCE

If I have insurance all deductibles and co-payments are expected at the time of service or by an office approved, signed payment plan. (A "deductible" is a specific dollar amount that your health insurance company requires that you pay out-of-pocket each year before your health insurance plan begins to make payments to any doctor for your healthcare claims.) If I do not have health insurance, I understand payment is due at the time of service, or I have the option of creating an approved, affordable payment plan.

RETURN CHECK POLICY

Each check that is returned to the office for insufficient funds will automatically be subject to a \$25.00 return check fee. Future payments must be made in guaranteed funds (cash, money order, debit card) and checks may not be accepted for a minimum period of six months.

CANCELLED OR MISSED APPOINTMENTS

I understand that a \$20.00 fee may be assessed at the Doctor's discretion for any prior scheduled appointment that I fail to attend without 24 hours advance notice to reschedule or cancel.

I have read or have had read to me, the above Office Financial Policy. I have also had the opportunity to ask any questions about its content, and by signing below I agree to this policy.

PATIENT NAME: _____ **DATE:** _____

To be completed by patient's Parent/Legal Guardian if the patient is under legal guardianship or minor

SIGNATURE OF PARENT/GUARDIAN: _____

RELATIONSHIP TO PATIENT: _____