Atlanta Center for Medicine

Financial Policy

Thank you for choosing Atlanta Center for Medicine (ACM) for your medical needs. Our staff is committed to providing you with the best care possible. Your clear understanding of the Financial Policy, which is an agreement between the practice and the patient or guarantor, is important to our professional relationship. We require a signature to document that you have read and understand this policy.

INSURANCE/PAYMENT: Insurance plans vary considerably and we cannot predict or guarantee what part of our services will or will not be covered. On arrival, please sign in at the front desk and **present your current insurance card and photo identification as well as any other forms that may assist us in processing your claims correctly at every visit**. It is the responsibility of the patient to provide *accurate* and *timely* insurance information. Inaccurate or untimely information given to the staff that results in denial or non-coverage by your insurance company results in the guarantor being responsible for payment. If the patient is not the policy holder on the insurance, we require the policy holder's full name, date of birth, social security number and relationship to the patient to file all claims. If your plan requires, you must name ACM as your primary care physician prior to your first appointment. If an ACM physician is not named on your insurance as your primary care physician, your appointment will need to be rescheduled. According to your contractual agreement with your insurance plan, **you are responsible for your co-payment, coinsurance, and/or deductible at the time of service.** It is important for you to be an informed consumer who understands the specifications of your insurance policy regarding doctor visit coverage, referral/authorization requirements for specialty care, imaging studies, laboratory tests, emergency hospital care, etc. You should refer to information from your insurance company or call them if you have questions about your coverage.

BILLING: We accept cash, checks, MasterCard, Visa, and Discover. **Outstanding balances are due within 30 days unless prior arrangements have been made with the billing department.** For balances over 60 days, you will receive a final request for payment letter. Balances not paid in full within 10 days of the date on the final request letter will be forwarded to a collection agency. **You will be responsible for any costs incurred if your account is turned over to a collection agency,** which will include collection agency fees equaling **25%** of the outstanding balance, and in addition, court costs and attorney fees.

The guarantor is responsible for full payment at the time of service. We realize that temporary financial problems may affect timely payment on your account. If such problems arise, we encourage you to contact our billing department promptly for payment arrangements and assistance in the management of your account.

Should your account balance become uncollectible due to bankruptcy, we will continue to see you on an emergency basis only for the next 30 days, giving you time to find a new source of medical care.

Please call if you have a question about your bill. Most problems can be settled quickly and easily and your call will prevent any misunderstandings. If you are having trouble paying your bill, please discuss the situation with us. Satisfactory arrangements can almost always be made.

IF WE PARTICIPATE WITH YOUR INSURANCE COMPANY: All services performed in our office will be submitted as a courtesy to your insurance. **All co-payments, deductibles, and coinsurance are due at the time of service.** All insurance carriers have a fee schedule from which they will reimburse. Not all services provided by this office are covered benefits in all contracts. Therefore, any balance not covered by insurance becomes the responsibility of the patient.

IF WE DO NOT PARTICIPATE WITH YOUR INSURANCE COMPANY: We are not able to bill your insurance and we cannot accept payment from them for the services performed. We will provide you with a bill so that you may submit the charges to your insurance company for reimbursement. **Payment for service is due in full at the time of service.**

IF YOU DO NOT HAVE INSURANCE: If you are not covered by insurance at the time of service, please be advised that **you will be responsible for all charges incurred at the time of service**.

NON-EMERGENCY APPOINTMENTS: We may reschedule non-emergency appointments if there is an overdue balance on your account or if a co-payment is not made at the time of service.

MISSED APPOINTMENTS/LATE CANCELLATIONS: Missed appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. For cancellations, a 24 hour notice prior to the appointment is requested. However, we understand emergencies arise, so please call us if you must miss an appointment. **We reserve the right to charge a $25.00 fee for missed appointments without proper notification ($150.00 for missed physicals).**

RETURNED CHECKS: A **$35.00 fee** will be charged for all returned checks. If you write a check that is returned, your account will be placed on a cash only basis, meaning we will only accept cash or credit card payments.

AFFIDAVITS/LEGAL MATTERS: Each Provider charges a fee for affidavits, letters, or forms that we prepare for legal or employment matters. Those fees are not billable to your insurance company or employer and are due at the time of service.

FORMS: We require at least 48 hours to complete all forms. An appointment may be required depending on the nature of the form and information requested.

MEDICAL RECORDS: If you request a copy of your medical records, you will be required to sign a medical record release form and pay a medical record fee prior to having your records copied (fee details stated on release form). Please allow up to 14 days for this request to be processed.

REFERRALS: If your insurance plan requires a written referral for you to see a specialist, for procedures, or laboratory tests, you must allow no less than 3 business days to complete the appropriate form(s) prior to obtaining services. You may have to reschedule your appointment if enough notice is not given to prepare your referral. Emergency referrals will be completed on the same day. Retroactive referrals cannot be written and will not be honored. In general, we will not agree to a referral for a problem we have not been consulted about first.

REFUNDS: If you have a credit on your account, we will gladly refund the amount within thirty (30) days of your request (and if cleared by the Billing Department). You must provide a correct mailing address for your refund to be sent.

DISMISSAL PROCESS: There are several reasons that a patient may be dismissed from our practice. A few reasons are as follows:

- Failure to keep scheduled appointments
- Being verbally or physically abusive to staff
- Abuse of prescription drugs and/or failure to adhere to ACM's narcotic policy
- Failure to meet financial obligations

A certified letter will be sent to your last known address notifying you that you are being dismissed from our practice. If you have a medical emergency within thirty (30) days of the date of the letter, one of our providers will be available for advice. After the thirty (30) days, you will no longer be seen at our practice by any provider. A copy of your medical record may be forwarded to your new doctor after a formal request is made and applicable fees (if any) are paid.

You may review this Financial Policy at http://acmdocs.com/

PLEASE DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT.

Patient Acknowledgement: *I, _____ (print name), have read, understand, and agree to the Atlanta Center for Medicine Financial Policy. I agree to pay at the time of service. I also understand that Atlanta Center for Medicine reserves the right to dismiss patients that fail to keep their accounts current after reasonable attempts to collect payments have been made. I further agree to pay all reasonable costs and late fees should my account be turned over to collections. I also understand the terms of this Financial Policy may be amended by the practice without prior notification to the patient or guarantor.*

_____

Patient's or Responsible Party's Signature Date

_____

Witness Signature Date