Atlanta Women's Obstetrics & Gynecology, PC
275 Collier Road NW ● Suite 230 ● Atlanta, GA 30309

FINANCIAL POLICY & PATIENT RESPONSIBILITY

Thank you for choosing Atlanta Women's Obstetrics & Gynecology, PC for your care. We are committed to providing you with prompt and courteous care of the highest quality. Knowing and understanding all of the policies of our practice is an important part of making sure that you have the best experience with us. Please read the Financial Policy & Patient Responsibility form and **provide your signature to acknowledge your understanding information provided.**

Patient Responsibility

- **PROOF OF INSURANCE/CHANGING INSURANCE:** You must present your insurance ID at the time of your visit. All patients are required to provide the most current and accurate insurance information. It is your responsibility to update AWOG of any changes to your insurance coverage.
- **INSURANCE COVERAGE:** It is your responsibility to verify that the physician you are seeing is in your insurance network. If a referral is required for your visit, please obtain this prior to being seen. Sometimes, services that are routinely covered by many plans may not be covered by your particular plan. It ultimately your responsibility to verify your coverage by contacting your insurance carrier.
- **CLAIMS SUBMISSION/DENIAL:** Our Billing Department will submit claims to your insurance company on your behalf and will assist you in getting your claims paid. However, you are required to respond in a timely manner to any information requests from this office or from your insurance carrier. If the claim is denied due to a nonresponse, you will be financially responsible for paying for the charges in full even if we are considered a participating provider.

- **CO-PAYMENTS:** If you have a co-payment, it is due at the time of service.
- **CO-INSURANCE AND UN-MET DEDUCTIBLES:** If your insurance requires a coinsurance payment and/or has a deductible you are responsible paying.

- **NON-COVERED SERVICES:** Some of the services we provide may not be covered under your insurance plan. If you elect to have a non-covered service, payment is expected in full at the time of service.
- **SELF-PAY PATIENTS:** If you do not have insurance or do not provide valid insurance information by the date of service, you are considered to be a self-pay patient. As a self-pay patient, you are responsible for payment in full on the date of service.
- **DEMOGRAPHIC INFORMATION:** It is your responsibility to update the office with any changes to your name, telephone number(s) and/or mailing address.

Practice Policies & Fees

- **OFFICE VISIT CANCELLATION POLICY:** A cancellation fee of $25 will be charged for neglecting to cancel or reschedule at least 24 hours prior to your scheduled appointment.
- **SURGERY CANCELLATION POLICY:** A fee of $100 will apply for rescheduling or cancelling an in-office surgery with seven (7) days of your scheduled procedure. A $250 fee will be applied for any in-office surgery rescheduled or cancelled within 36 hours of your scheduled procedure. You will be charged $250 for rescheduling or cancelling a procedure more than once regardless of prior notice.
- **NO-SHOW POLICY:** You will be charged $25 for each no-call/no-show. If you miss 3 or more visits without calling to reschedule 24 hours in advance you may be dismissed from the practice.
- **REQUEST FOR MEDICAL RECORDS:** Our office must receive your written authorization for the release of health information at least 72 hours prior to the date needed. In some cases, a $35 fee will be required before records are released.
- **PAYMENT METHODS:** For payments we accept cash, personal checks, money orders, cashier's check, MasterCard, Visa, and American Express. We do not accept post-dated checks. A $35 fee will be applied for each returned check.
- **REBILLING FEES:** A monthly rebilling fee of $5.00 will be assessed to your account for any balance that is over 90 days old.

By signing my signature below, I acknowledge that I have read and understand the Financial Policy and Patient Responsibility form.

Patient Signature

Today's Date