

******* FINANCIAL POLICY *******

We appreciate the opportunity to provide medical services to you this year. Our goal is to keep your financial arrangements as simple as possible by timely filing of claims and using the following guidelines:

1. You are ultimately responsible for payment of charges for services received at our office.
2. A fee of \$30 will be added to your account for any check dishonored by your bank.
3. It is your responsibility to provide us with your current address, phone number and insurance information at each visit.
4. It is your responsibility to confirm with your insurance carrier that our doctor is your PCP prior to seeing the doctor. If you choose to see a provider who is not on your plan you will be responsible for payment in full.
5. All co-pays are due at the time of service. Failure to pay your co-pay at the time of service will result in an additional \$25 fee added to your account.
6. If you miss your appointment a NO-SHOW fee of \$25 may be added to your account.
7. Laboratory services are provided by a contracted outside lab. Lab charges not covered by your insurance will be billed to you by an independent lab billing service.
8. ASF (Administrative Service Fees) May be paid annually at \$25 per year to cover all your administrative forms for one year. Or you may choose a "fee per form" status and fees will be assessed at the time the form is completed. These "per form" fees range from \$10 to \$150. Examples of these forms are:
 - a. Adoption
 - b. School/ College PE
 - c. Parking permits
 - d. Immunizations
 - e. DOT/ FAA
 - f. Work/ School Release
 - g. FMLA
 - h. Computer generated forms

Remember: If you elect not to pay the ASF fee today, you will be charged the administrative fees when services are requested. Please Initial your choice below:

I elect to pay the ASF annual fee today _____

I elect to pay a "per form" fee at the time service is rendered _____

I acknowledge and agree with the terms of this financial policy. I authorize payment of benefits to North Atlanta Primary Care for services rendered under the terms of my insurance policy. I authorize North Atlanta Primary Care to release any medical information necessary to process insurance claims.

Responsible Party

Signature _____ **Date** _____

North Atlanta Primary Care

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