



FINANCIAL PAYMENT POLICY

We find that communication with our patients regarding our financial policy assists us in providing the best service to you. We have therefore taken the time to answer some of the most commonly asked questions.

How may I pay?

We accept payment by cash, check, VISA, MasterCard, Discover, and American Express.

What is my financial responsibility for services?

Your financial responsibility depends on a variety of factors, explained below.

<i>If you have.....</i>	<i>You are responsible for.....</i>	<i>Our staff will.....</i>
Commercial Insurance Medicare Medicare Replacement	Payment of the patient responsibility for all office visits, injections, office procedures and other charges at the time of office visit.	File an insurance claim as a courtesy to you.
HMO & PPO plans with which we have a contract	<u>If the services you receive are covered by the plan:</u> All applicable copays and deductibles are requested at the time of visit. <u>If the services you receive are not covered by the plan:</u> Payment in full is requested at the time of visit.	File an insurance claim on your behalf.
HMO with which we are not contracted and are not applying for.	Payment in full for office visits, injections, office procedures and other charges at the time of visit.	Provide the necessary information for you to complete and file your claim directly with the insurance company.
Point of Service Plan or Out of Network PPO	Payment of the patient responsibility – deductible, copay, non-covered services-at the time of the visit.	File an insurance claim on your behalf.
No Insurance	Payment in full required at the time of service.	

We feel strongly that it is the patient's responsibility to be aware of the requirements and limitations of their own benefits and insurance plans. Please let our office know if your insurance has requirements regarding participating outpatient facility and laboratory. For services rendered in our office and out patient facilities please note that you may also receive bills from other non-Saint Joseph's entities for services rendered in conjunction with your care (i.e, laboratory services).

Any patient who is seen and fails to notify our office of any changes in their insurance that in turn deems their services as non-covered will be billed directly for these charges. In exchange for filing your insurance, you agree to provide current insurance information and picture I.D at every office visit. We understand that filling out forms is at times tedious; we do our best to simplify this process.

Co-pays are required at the time of the visit.

Check Policy

We are happy to accept your personal check for payment toward your account balance. However, if funds are not available in your account and your check is returned to us as a NSF (or for any other reason), you will be assessed a \$35 service fee plus the amount of the original check. You may be required to make future payments using cash, credit card or money order.

No Show Policy/ Late Cancellation Policy

Any time that you miss an appointment in our office or cancel an appointment without giving us 24 hours notice, you will be assessed a \$35-\$250 for no-show/late cancellation fee. The fees for the most common appointments are listed below:

Appointment Type	Fees
Office Visit	\$35-\$50
Physical Exam	\$50
Surgery- Office Procedure	\$125
Surgery- Hospital procedure & Nuclear Testing	\$250

This fee will be your responsibility and must be paid in full prior to your next visit. Dismissal from our practice may result following 3 No Shows.

Application/ Form Completion Fees

A prepayment fee up to \$35 must be paid in full for forms and applications completion such as school physical, sport physical, disability application, and others that do not require you to come to the office.

Medical Record Fees

Charges for Medical Records copies will be determined in accordance with the current State of Georgia Office of Planning and Budget published rates. Minimum costs are approximately \$25.00 as a base fee in addition to a **per page cost of \$1.00.**

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable co-payments, deductibles, and co-insurance amounts, are my responsibility.

Date

Signature

Printed Name