

Our goal at Perimeter North Family Medicine is to make sure your health care experience is delivered with thoroughness and with the utmost in quality. We want to keep your insurance or other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner, we ask that you adhere to the following guidelines:

1. You are ultimately responsible for payment of services rendered from our office. Please contact your insurance company to confirm coverage and benefits. We can **NEVER** guarantee coverage for any service provided by our office. You are responsible for any balance left after all insurance payments and contracted adjustments are applied.
2. It is your responsibility to provide us with your current address, telephone number and insurance information at each visit. Please be prepared to present your insurance card at each visit.
3. It is your responsibility to contact your insurance carrier to confirm that our physicians participate in your plan.
4. All co-payments are due at the time of service. A \$25.00 service fee will be assessed for failure to pay your co-pay at the time of service.
5. If you miss your appointment you may be charged a no-show fee of \$25.00 for each appointment missed.
6. There is a \$25.00 fee for checks not honored by your bank.
7. All patient balances aged over thirty days will be assessed a **late charge** of \$10.00 per month until the balance is paid.
8. Our office collects an optional \$15.00 Administrative Services Fee one time per calendar year. This administrative fee is intended to cover the cost of certain administrative services we may provide that are not covered by your insurance. You are not required to pay the Administrative Services Fee. However, if you choose not to pay the optional Administrative Fee you will be charged for all non covered administrative services as needed. A list of our administrative services with associated fees is included with this Financial Policy.
9. Patients prescribed Schedule II controlled substances are **required** to pay the \$15.00 Administrative Services Fee to cover the associated costs due to compliance with new Georgia state law.

I understand the services listed below are included in the **Administrative Services Fee**. I understand that, if I elect not to pay the Administrative Services Fee, I will pay for the services, as I need them, at the fees listed below.

Billable items on a requested basis- list includes but is not limited to:

1. Completion of all forms (to include but not limited to): \$50.00/form
  - a. Adoption forms
  - b. Camp forms
  - c. FMLA, disability, life insurance forms
  - d. Foreign travel forms
  - e. School forms
  - f. Sports Physical forms
  - g. Other miscellaneous administrative forms required by third parties other than your insurance company
  
2. Patient requested computer generated reports ( additional claims, statements, payment histories, etc.): \$15.00/request
  
3. Copying of medical records: \$35.00/request
  
4. Other administrative services that are not a covered service/benefit under your certificate of insurance: \$30.00/request
  - a. Chart review for medication prior authorizations
  - b. Chart review for medication refill requests
  - c. Chart review for referral requests
  - d. Review of documents and consultations pertaining to healthcare
  
5. Prescriptions for Schedule II controlled substances: \$15.00/year

All of these activities add to our cost of caring for patients. Still, we are committed to providing you the best possible care. With you, our patient, we look forward to a lasting and healthy relationship and we thank you for your understanding and cooperation.

- I accept the financial policy that includes payment of the Administrative Service Fee.
  
- I accept the financial policy but choose not to pay the Administrative Services Fee.  
I understand the services listed on the next page are included in the Administrative Services Fee. I understand that, if I elect not to pay the Administrative Services Fee, I will pay for the services, as I need them, at the fees listed.

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date