GWINNETT MEDICAL GROUP

PATIENT FINANCIAL RESPONSIBILITIES

Patient Name (print):_____ Date of Birth: _____

Thank you for choosing a Gwinnett Medical Group practice as your health care provider. We are committed to providing you with quality and affordable health care. Please review and sign this policy, asking questions as necessary. A copy of this document will be offered to each patient.

1. **Registration:** All patients shall complete the Patient Information form, which will be used to ensure accurate information for proper billing. We must obtain a copy of your photo ID and current valid insurance card in order to validate your coverage. If you fail to provide us with the correct insurance information, or your insurance changes and you fail to notify us in a timely manner, you will be responsible for the balance of a claim.

2. **Patient Payment**: All patient payments are due at the time of service. This includes co-payments and deductibles. This arrangement is part of your contract with your insurance company. If we are not able to verify insurance, you will be responsible for payment at the time of service.

3. **Insurance Plans**: We accept assignment and participate and file most insurance plans. Your insurance may not cover all services, and knowing your insurance benefits is your responsibility. Please contact your insurer with any questions regarding your coverage to receive the maximum benefits

4. **Claims:** We will submit your claim based upon service provided at the time of your visit. Your insurance company may request additional information from you. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays or not. Your insurance benefit is a contract between you and your insurance company; we are not party to your insurance contract.

5. **Self-Pay Patients**: We offer a prompt payment discount to our patients who do not have insurance or for non-covered services.
6. **Credit and Collection**: If your account is past due, you will receive a statement with your balance due. If a balance has remained unpaid, it will be sent to a collection agency.

7. **Missed Appointments:** There is a $25.00 charge for missed appointments. If you need to cancel your appointment, please notify our office at least one business day, prior to your appointment. These charges will be your responsibility and billed directly to you. Please help us serve you better by keeping your regularly scheduled appointment.

8. **Forms:** There are charges for completion of certain forms.

9. **Assignment of Benefits**: I hereby agree to assign and transfer to Gwinnett Medical Group and treating Physicians all benefits and payments now due and payable or to become due and payable to me under any insurance policy or benefit plan or program for this visit and outpatient care.

I have read and understand my financial responsibilities and agree to the guidelines.

Signed: _____ _____ _____ _____

Patient/Patient Representative Print Relationship Date Signed