Peachtree Primary Care, PC

1570 Old Alabama Rd, Suite 105 Roswell, Georgia 30076
Telephone: 770-676-6838 Fax: 770-676-6840

FINANCIAL POLICY& ASSIGNMENT OF BENEFITS

Thank you for choosing Peachtree Primary Care, PC., for your healthcare needs. We are committed to providing you with the best medical care possible.

Our staff will be pleased to explain our financial policy to you at any time. We ask that patients thoroughly read this policy and assignment of benefits, as well as complete our patient information form prior to seeing the physician. Payments for services are due at the time such services are rendered. We accept most major medical insurances as well as cash, checks and all major credit cards. Although we will file insurance claims on your behalf, you must understand:

a) *Your insurance policy is a contract between you and your insurance company. We cannot assist with disputes between you and your insurance carrier regarding customary matters such as; deductibles, copayments, covered charges and secondary insurance coverage. We are contracted with many managed care plans. We follow their guidelines for reimbursement and submission of claims for services rendered.*

b) *All charges are patient's responsibility whether or not services are covered by your insurance carrier. Since some services are not considered covered benefits, it is important that you discuss such services with your insurance carrier in advance.*

c) *Fees for services, copayments and any unpaid balances are due at the beginning of visit*

d) *If you have a high deductible health plan, we may collect payment at the time of visit*

e) *If your insurance company does not pay the claim within 30 days, it is your responsibility to contact your insurer to expedite the payment.*

f) *Returned checks are subject to a $35 fee. Balances older than 90 days are subjected to collection agency placement. This could result in additional collection fees and possible attorney fees.*

g) *It is your responsibility to provide us updated information regarding your insurance/address or phone number changes.*

Patient Name (print): _____ **Date:** _____

Patient Signature: _____