North Georgia Endocrinology

North Georgia Endocrinology
3180 North Point Parkway, Suite 302
Alpharetta, Georgia 30005

Phone: (678) 224-8686 * Fax: (770) 224-8779

FINANCIAL POLICY

If covered by health insurance, please present a current insurance identification card. Please notify our office if your coverage should change. It is the responsibility of the patient to obtain a referral if needed, All co-payments will be collected at the time of service before your visit with the provider. **Deductibles, co-insurance, and any unpaid balance will also be collected at the time of service.** As a courtesy to you, we will file your claims for you. For your convenience we accept cash, VISA, Mastercard, Amex and Discover. **We do not accept checks.** If your insurance company does not pay your claim, you will be responsible for the balance. If you are a private pay patient, payment in full is expected at the time of service unless prior arrangements have been made. Statements will be sent every thirty (30) days. Unpaid accounts will be sent to an outside collections agency at ninety (90) days. You will also be responsible for a collection fee of 25% of the past due amount.

Charges for copying medical records are based on the charges set forth by the Georgia Office of Planning and Budget pursuant to O.C.GA. 31-33-3. In order to comply with HIPAA regulations, a signed, written request for medical records must be received along with the payment before records can be released.

If you are unable to keep your appointment or need to change it, please call our office at 678-224-8686 at least 24 business hours prior to the scheduled appointment to avoid being charged a **$50.00 rescheduling fee**.

There is a $50.00 fee for follow-up patient "no shows." Please remember it is the patient's responsibility to keep up with scheduled appointments, but as a courtesy we do our best to provide a reminder call two days prior to the scheduled appointment as well as reminder text messages and emails closer to the appointment date. Two consecutive “no shows” in a row will result in dismissal as a patient from our practice and the inability to schedule new appointments.

* **All outstanding balances MUST BE CLEARED prior to scheduling or being seen at a follow up appointment.** Prescription refills will also be halted, unless deemed urgent for a one time refill, until all balances are cleared. Accounts outstanding for 3 months will automatically be sent to collections.

I have read and understand the above financial policy:

Signature: _____ Date: _____

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1. PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorized you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.
I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

2. PATIENT AUTHORIZATION FORM:

This authorization sets forth your right to use or disclose my protected health information as specified below for the purposes and parties as designated below.

DESCRIPTION OF SPECIFIC INFORMATION AUTHORIZED:
Any information needed to process insurance claim forms.

DESCRIPTION OF THE SPECIFIC PURPOSES FOR USE AND DISCLOSURE:
Billing purposes

PARTIES REQUESTING INFORMATION AND AUTHORIZED TO USE AND DISCLOSE THE INFORMATION:
Authorized representative of my insurance carrier

PARTIES TO WHOM INFORMATION MAY BE DISCLOSED:
Authorized representative of my insurance carrier

I reserve the right to:

- Revoke this authorization in writing by submitting it to the attention of your Privacy Officer
- Inspect or copy the protected health information to be used or disclosed
- Refuse to sign this authorization knowing that you will condition treatment or payment on my providing this authorization (except for research related treatment)

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by HIPAA.
Under certain circumstances we may receive compensation from a third party requesting your medical records.

Print Patient Name: _____

Signature: _____