Financial Agreement

We, the staff of Advanced Internal Medicine, thank you for choosing us as your Health provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest quality care and building a successful provider-patient relationship with you and your family. We believe your understanding of our patients' financial responsibility is vital to that provider-patient relationship. Our goal is to not only inform you of the provisional aspects of that financial policy, but also to keep the lines of communication open regarding them. If at any time you have any questions or concerns regarding our fees, policies, or responsibilities; please feel free to contact billing at 770-960-8855.

Please understand that payment for services is an important part of the provider/patient relationship. If you do not have insurance, proof of insurance, or participate in a plan that will not honor an assignment of insurance benefits, payment for services will be due at the time of service unless a payment arrangement has been approved in advance. **We realize that temporary financial problems may affect timely payment of your account. If this should occur please contact us for assistance in the management of your account.**

We accept payments for your convenience: cash, money order, MasterCard, Visa and in-state checks. A $35.00 service fee will be charged for all returned checks. Additionally, you may authorize us to keep your credit card on file for your convenience knowing that we adhere to the highest level of information security.

Insurance

Please remember that your insurance is a contract between you and your insurance carrier. It is your responsibility to provide all necessary insurance eligibility, identification, authorization, and referral information and to notify our office of any information changes when they occur. Even a pre-authorization of services does not guarantee payment from your insurance carrier. It is the patient's responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, we are contractually obligated to collect co-payments, co-insurance, and deductibles, as outlined by your insurance carrier. Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions, or reductions such as reasonable and customary or usual and prevailing reductions. You as the guarantor are responsible for all out-of-network fees. If we are not contracted with your carrier, we will **not** negotiate reduced fees with your carrier.

Miscellaneous Forms, Additional Information, and Authorizations

We will provide all necessary information to have your benefits released. However, if it becomes necessary to submit redundant or unnecessary information for the completion of the claim forms for school, sports, or extra-curricular activities; there will be an administrative fee, not to exceed **$25.00**, for the additional information.

Missed Appointments

We require notice of cancellations 24 hours in advance. This allows us to offer the appointment to another patient. If you fail to keep your appointments without notifying us in advance: a missed appointment fee of **$25.00** will apply. Repeated missed appointments without notification may cause you to be discharged from the practice so that we can provide care to other patients.

Medical Records Fees

Patients are entitled under federal law to have access to their protected health information and we follow all rules, guidelines and exceptions to ensure compliance to patient rights. However, **providers also have the right to be compensated for records, filling of forms, or any administrative paperwork**. Our fees are a reasonable cost-based fee for copies including the copying, supplies, labor, and postage of the files and or summaries.

I have read and understand the above financial policy. I agree to assign insurance benefits to Advanced Internal Medicine whenever applicable. I also agree, in addition to the amount owed, I am responsible for all costs of collections if such action becomes necessary.

Patient Name (printed): _____ Patient Signature_____

Today's Date: _____