PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Atlanta ID Group (AIDG) as your healthcare provider. We are honored by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

• The patient (or patient's guardian, if a minor) is ultimately responsible for the payment of his/her treatment and care.

• We are pleased to assist you by billing for our contracted insurers however, the patient is required to provide us with the most correct and updated information.

• Patients are responsible for the payment of co-pays, co-insurance, deductibles and all other procedures or treatments not covered by their insurance plan. Payment is due at the time of service and for your convenience we accept cash, check, and most major credit cards at our office. Any payments received by AIDG may be applied to any unpaid bill(s) for which the patient is liable. Any and all balances assigned as patient responsibility may be subject to collection efforts after 90 days, as well as credit reporting.

• Patients are to be aware that our Laboratory services are provided by Quest Laboratories. They are not affiliated with AIDG and there may be an additional charge if your insurance coverage does not include this laboratory. Please check with your insurance company. Any questions about billing from laboratories are to be resolved by contacting the lab company directly.

• Patients may incur, and are responsible for the payment of additional charges. These charges may include (but are not limited to): • Charge for returned checks • Charge for extensive phone consultations and /or after-hours phone calls requiring diagnosis, treatment of prescriptions. • Charge for the copying and distribution of patient medical records. • Any costs associated with collection of patient balances.

• By my signature below, I acknowledge and understand that missed appointment without 24-hours advance notice will incur a $50 fee which must be paid in full before future appointments will be scheduled.

• By my signature below, I acknowledge and understand that it is ultimately my responsibility and obligation to be aware of my insurance's requirements, coverages, deductibles and payments.

• By my signature below, I hereby authorize AIDG and the physicians, staff, and hospitals associated with AIDG to release medical and other information acquired in the course of my examination and/or treatment to the necessary insurance companies, third-party payors, and/or other physicians or healthcare entities required to participate in my care.

• By my signature below, I hereby authorize assignment of financial benefits directly to AIDG and any associated healthcare entities for services rendered as allowable under standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment. I understand that account balances not paid by my insurance company within 90 days are the patient's/my responsibility. I also understand that account balances not paid within 90 days from the date of service will be sent to collections.

• By my signature below, I authorize AIDG personnel to communicate by mail, answering machine message, voicemail, and/or email according to the information I have provided in my patient registration information. I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form:

_____ _____

Print Last Name First Name **Date of Birth**

_____ _____

Signature of Patient or Legal Guardian Today's Date

Date Waiver of Authorization: I do not wish to have information released and prefer to pay at the time of service and/or to be fully responsible for payment of charges and /or to submit claims to insurance at my discretion.

_____ _____

Signature of Patient or Legal Guardian Date Patient Financial Responsibilities Patient Authorizations Today's Date

_____ _____

Witness Signature Today's Date