Atlanta Surgery Associates

Statement of Patient Financial Responsibility

Patient Name: ____ DOB: _______________________

Atlanta Surgery Associates appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to Atlanta Surgery Associates, for providing medical services to me, the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Atlanta Surgery Associates, the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient Signature ____ Date ___________________________

Guarantor Signature ____ Date ___________________________
(If guarantor is not the patient)

Co-Pay Policy

Some health insurance carriers require the patient to pay a Co-Pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Patient/Guarantor Signature ____ Date ____________________________

Consent for Treatment and Authorization to Release Information

I hereby authorize Atlanta Surgery Associates, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

I further authorize Atlanta Surgery Associates, to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

Patient/Guarantor Signature ____ Date ____________________________

Cancellation / No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to canceling your appointment.

I understand if I no show for two consecutive appointments, no show for three appointments or cancel for a total of four appointments, I may be discharged from care.

Atlanta Surgery Associates will notify you in writing, via certified mail, if you are discharged from care.

I have read and understand the above information, and I agree to the terms described:

Patient/Guarantor Signature ____ Date ____________________________

Self-Pay

I do not have health insurance and will be responsible for services rendered here at Atlanta Surgery Associates. I agree to pay Atlanta Surgery Associates, the full and entire amount of treatment given to me or to the above named patient at each visit.

Patient/Guarantor Signature ____ Date ____________________________

FMLA Paperwork

FMLA forms or Short Term disability paperwork needs to be given to us at least 5 days in advance of your surgery. There is also a charge of $25 for ALL paperwork to be filled out that needs to be paid before we will complete. This fee is not billable to your insurance company. Additionally, any balance on your account must be paid prior to these forms being filled out.

Patient/Guarantor Signature____Date__________________________

Motor Vehicle Insurance (PIP)

I do not have health insurance. I request my claims be submitted to my motor vehicle carrier. I understand I will be responsible for bills incurred by me in the event my PIP benefit exhausts or denies.

Patient/Guarantor Signature ____ Date ____________________________