Internal Medicine Associates of Middle Georgia's

Financial Policy

Thank you for choosing Internal Medicine Associates of Middle GA as your healthcare provider. It is our goal to provide quality medical care for our patients. Our staff will be available to discuss our fees and policies with you. The healthcare that you have chosen to participate in implies a financial responsibility on your part.

We ask that all responsible parties read and sign our financial policy, as well as complete the patient information forms before seeing the doctor.

To accommodate the needs and requests of our patients, we have enrolled in numerous managed care insurance programs and we file these claims and work with you for you to receive the full insurance benefits you are entitled. While we work with you, we also ask that you work with us to ensure timely payment from your insurance carrier and if your insurance company requires information from you regarding specific claims we ask that you contact them immediately to resolve the issue at hand.

Payments that are due from the patient (co-payments; co-insurance; outstanding balances) will be expected at the time services are rendered. If you have an outstanding balance on your account that you can't pay in full, we ask that you speak with the proper staff member to set up payment arrangements. In order to serve you better, we accept cash, check, Visa, MasterCard, and Discover. You can also pay your bill online at internalmedicineamg.com.

Please initial the following:

___1. As a medical provider, we supply only factual information to facilitate processing your claims with your insurance company. We will not become involved in disputes between you and your insurance carrier regarding deductibles, co-payments, covered charges, secondary insurance and "usual and customary" charges.

___2. Fees for services, which include unpaid balances, deductibles, co-payments and in some cases, co-insurance, are due at the time of service. Returned checks and unpaid balances that are considered delinquent, may be subject to collection placement and collection fees. Any check that is returned to Internal Medicine Associates of Middle GA for insufficient funds will be subject to a $30 non-sufficient funds fee plus the amount of the check, and will be expected to be picked up by cash payment within 15 days.

___3. If your insurance carrier does not remit payment within 60 to 90 days of visit, we will refile your visit. However, if after the second filing we do not hear from your carrier and we have rechecked all the necessary information, we will turn the balance over to the patient and it becomes your responsibility to remit payment to this office for the services that were rendered.

___4. I understand that if any payment is made directly to me for services billed by Internal Medicine Associates of Middle GA, I recognize that it is my responsibility to promptly remit payment to Internal Medicine Associates of Middle GA.

___5. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, after such default and upon referral to a collection agency or attorney by Internal Medicine Associates of Middle GA, I will be responsible for all costs of collecting monies owed, including any collection agency fees that may be added to my balance.

___6. The above does not apply for those patients that are considered Workers' Compensation. However, be advised that as a compensation patient you may be held responsible for charges in the event that your claim is denied or not paid or determined not to be work related.

___7. I understand that if I fail to provide Internal Medicine Associates of Middle GA with the correct insurance information and should the claim be considered untimely by my insurance company that I will be responsible for those services that were rendered and the balance of those services will be totally my responsibility.

___8. I understand there are services that may be deemed "not medically necessary" by my insurance carrier yet my physician considered them necessary for my treatment. In the event of this determination, I will be responsible for those fees.

We do understand that due to circumstances beyond your control, there may be times when you are unable to meet your obligations. Through the years, we have always cooperated with our patients during their difficult financial times and we will continue to do so. In order to help you, you MUST let us know of these times and we will be glad to make arrangements that will help you as well as Internal Medicine Associates of Middle GA. You will receive quality medical care in good faith, please respond in like manner to your responsibility of your debt.

I UNDERSTAND THE ABOVE INFORMATION AND WILL BE RESPONSIBLE FOR THE PATIENT LISTED BELOW.

Print name of patient _____

_____ _____

Signature of patient or responsible party Date

_____

Relationship if other than patient