PERIMETER CLINIC ATLANTA

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Practice Financial Policy

- Office co-pays, deductibles, and out of pocket percentages mandated by your insurance company are required at the time of service.
- Co-pays not paid at the time of service will be subject to a $5.00 late fee
- Insurance claims will be filed at no additional cost to you.
- Payments for non-covered or self pay services are expected at the time of service.
- Returned checks are subject to a handling fee of $30.00
- Any account balance 90 days past due may be turned over to a collection agency and any fees assessed will be passed onto the account holder.
- We reserve the right to discharge a patient from the practice for non-payment and/or non-compliance.
- Some lab tests performed require additional testing by the laboratory. A charge for additional testing is passed on to the physician and will be charged to you or your insurance company.
- Some insurance companies require our office to file claims within a certain time period. If you do not provide us with CURRENT insurance information, you will be billed for any charges that our office is unable to collect from your insurance company.
- Your insurance policy is a contract between you and your insurance company. Not all services are covered under your insurance policy. We encourage you to contact your insurance carrier for current benefit information.
- There is a fee associated with the release of medical records to you or a life insurance company. GA Copy law code (31-33-3).
- There is a fee associated with any medical forms you require your physician to fill out.
- A fee of $25.00 will be charged for failure to cancel any scheduled appointment and $50.00 for a scheduled physical.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Perimeter Clinic to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). (Perimeter Clinic's Notice of Privacy Practices provide a more complete description of such uses and disclosure.) I have the right to review the Notice of Privacy Practices prior to signing this consent. Perimeter Clinic reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Perimeter Clinic at 6105 Peachtree Dunwoody Rd, C125, Atlanta GA 30328. With this consent, Perimeter Clinic may contact my home or other location and leave a message on my voicemail _____ **(initials here)** or in person in reference to any items that assist the clinic in carrying our TPO, such as appointment reminders, insurance issues, and any calls pertaining to my clinical care, including laboratory results, etc. With this consent, Perimeter Clinic may mail to my home or other location any information that assists the clinic in carrying out TPO. I have the right to agree to my requested restrictions, but it is bound by this agreement. By signing this form, I am consenting Perimeter Clinic's use and disclosure of my HPI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Perimeter Clinic may decline to provide treatment to me. This authorization will remain in effect until revoked in writing.

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Patient Signature Date