

**PEACHTREE GYNECOLOGY**

Last Name		First Name		MI	Social Security #	Birth Date		
Address				City		State		Zip Code
Home Phone		Work Phone		Cell Phone		YOUR Email Address		
Spouse/Significant Other				Should we contact this person in case of Emergency?			Contact Phone	
If you are under 18, who is financially responsible?				Resp. Party Contact #:		Marital Status:		
						M   S   D   W		
Primary Care Provider :		PCP Phone:		Referring Provider:		Referring Phone:		
Pharmacy Name:				Pharmacy Location :		Pharmacy Phone:		

**PRIMARY INSURANCE**

**SECONDARY INSURANCE**

Insurance Name		Insurance Name	
Subscribers Name	Gender M <input type="checkbox"/> F <input type="checkbox"/>	Subscribers Name	Gender M <input type="checkbox"/> F <input type="checkbox"/>
Subscribers ID	Group No.	Subscribers ID	Group No.
Subscribers Birth Date	Subscriber SS#	Subscribers Birth Date	Subscriber SS#
Patient's Relation to Subscriber: Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		Patient's Relation to Subscriber: Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	

**FINANCIAL POLICY & ASSIGNMENT (Please read in entirety before signing)**

I request that all insurance benefits be paid directly to Peachtree Gynecology. I permit a copy of this authorization to be used in place of the original.

You are entitled to a clear understanding of your financial obligations before services are rendered. We participate with numerous managed care plans. It is extremely difficult for us to know all of the individual requirements of each plan. Your employer negotiates the benefits of your plan. Each plan is different regarding what is covered, how often and where services may be rendered. Whether you have insurance or not, we maintain that you are ultimately financially responsible for all charges incurred.

We do not file indemnity plans or any other plan that we do not have a contract with, unless it is for out of office surgery. If we are not informed of any special requirements in your contract and we subsequently order services that are not covered by your plan, you will be billed by us and any ancillary provider associated with the service. Services that are filed and not paid by your plan (for whatever reason) become your responsibility. You are encouraged to follow-up on all claims submitted on your behalf.

It is your responsibility to ensure that a referral has been obtained, if necessary. We are contracted as a Specialist under your plan.

If you do not have your insurance card you will be expected to pay in full today. We accept Cash, Checks, Visa and MasterCard.

If you do not have insurance you will be expected to pay in full today (unless prior arrangements have been made).

If surgery is scheduled, we will do the authorization, verify your coverage and benefits and collect any deductible and/or percentage of the surgery fees in accordance with our contract with your carrier, prior to surgery. We charge 250.00 for non-emergent surgery cancellations or reschedules without seven (7) days notice.

\*\*\*\* All co-pays are payable at the time of service, without exception.

\*\*\*\* There is a 50.00 fee for returned checks.

\*\*\*\* There is a 50.00 fee for missed appointments without a 24 hour notice.

\*\*\*\* There is a 20.00 fee for charge ticket retrieval and duplication.

\*\*\*\* There is a fee associated with obtaining a copy of medical records.

\*\*\*\* This office practices Credit Bureau reporting for all delinquent unpaid balances.

I have read, understand and accept the terms of this financial policy.

Signature \_\_\_\_\_

Date \_\_\_\_\_