partners of augusta

1348 Walton Way Suite 4100
Augusta, Ga. 30901
Ph. (706) 722-1381 Fax (706) 823-6871
2004 Parkview Drive
Evans, Ga. 30809

NAME:
DOB:

MRN:

CONSENT TO TREATMENT

I hereby consent and authorize OBGYN Partners of Augusta, P.C. and staff to perform any service deemed appropriate by attending physician(s) to make a thorough diagnosis. I also authorize OBGYN Partners of Augusta, P.C. and staff to perform any procedures, forms of treatment, medication, and therapy in connection with my diagnosis and treatment plan.

FINANCIAL POLICY

Thank you for choosing OBGYN Partners of Augusta, PC for your healthcare needs. We are sincerely committed to providing you with the best possible care. Your understanding of our financial policy is a necessary part of our treatment program. We have outlined the most common financial/insurance issues for your convenience. If you need further information, please ask to speak with our Billing/Insurance office or our Administrator.

INSURANCE: You must provide your insurance card each visit at check in. Your medical insurance coverage is a contract between you and your insurance company. If you are not sure whether or not your insurance will pay for a particular service, you should check with your insurance company prior to having the service performed. Co-pays must be paid at check in. If you are not prepared to pay your co-pay at the time of your visit, we reserve the right to reschedule your appointment at our earliest convenience. Additionally, your insurance company requires us to collect.

If you do not have insurance, payment in full is expected at the time of service. We accept cash, checks (verifiable), debit cards and credit cards, including Visa, MasterCard, and Discover.

We do not accept Medicaid as a secondary insurance.

LAB SERVICES: If your insurance company requires your lab work to go to a specific lab, it is your responsibility to inform our staff. If you do not tell us where to send your lab work, it will be sent to our contracted lab.

BILLING: We file your insurance for you as a courtesy. Anything not covered by your insurance is your responsibility. You will receive a bill from us for any balance unpaid by your insurance company. The balance is due upon receipt of the bill. If you need to set up payment arrangements, it is very important that you call promptly to arrange this. Balances are considered past due 28 days after you receive your first bill and are transferred to our in-house collections department at this point. Overdue accounts will accrue interest at the rate of 1.5% per month. If we send three statements with no response from you, we reserve the right to cancel any appointments you have scheduled and we may obtain the services of an outside collection agency to collect your balance. In this case, any fees we incur in this process will be added to your balance and will become your responsibility.

MISSED APPOINTMENTS: OBGYN Partners of Augusta, PC reserves the right to charge a fee of $25.00 for missed appointments that you have not provided notification to our office 24 hours in advance. Multiple missed appointments can lead to dismissal of a patient from our practice, upon the physician's discretion.

FORMS/PAPERWORK: Forms and paperwork, including but not limited to disability and FMLA, will be filled out for you for a $15 charge for the first form. Any additional forms will be $10 each. Payment is due at the time of the request. Paperwork is completed as time permits and you will be notified when it is complete.

RETURNED CHECKS: If your check is returned for NSF we will charge the account $12 and run the check back through the bank. If the check is returned a 2nd time, we will charge the account an additional $30.

If the account is closed or a check is otherwise unable to be run back through the bank, we charge the $30 fee.

If we obtain an authorization from CrossCheck and the check is returned, we charge the account the $30 fee and file a claim for reimbursement from CrossCheck. CrossCheck will also bill the patient their associated fees.

Patients with accounts having a history of nonpayment are subject to being dismissed from this practice.

I have read and understand the financial policy of the practice and I agree to be bound by its terms.

Signature:
Date: