OFFICE POLICIES AND PROCEDURES FOR NORTH ATLANTA ENDOCRINOLOGY & DIABETES

Thank you for choosing North Atlanta Endocrinology & Diabetes for your healthcare needs. We are dedicated to providing excellent treatment and want you to have a full understanding of our office policies. Please acknowledge your agreement to these policies by initialing beside each statement.

____ Payment for services rendered including co-payments, coinsurance or deductibles **are due at the time of service**. **Furthermore, if your deductible has not been met, we will collect $100.00 upon check in to go towards any balance you may owe after your insurance has processed the claim.** We accept cash, check, debit and all major credit cards. If you are unable to pay on the date of your appointment you will be asked to reschedule.

___ We do not hold or accept postdated checks. Also, if funds are not available in your account and the check is returned to us as an NSF (or for any other reason), **you will be assessed a $37.00 service fee plus the cost of the original check.** All checks returned to our office are sent to an outside agency (Envision) for collection**. After one NSF we will no longer accept checks from the patient**. Going forward, all fees must be paid by cash or with credit card.

____ While we will gladly file all charges to your insurance**, please remember that a contract exists between you and the insurance company, not with our office**. If your insurance company does not pay our office within a reasonable time period**, we will have no choice but to seek payment from the patient**.

____ If your insurance requires a referral from your Primary Care Physician, it is **YOUR RESPONSIBILITY** to obtain that referral. We will not be able to see you without a current referral on file. However, if you choose not to obtain a referral, you may become a self-pay patient for that visit only. You will be given a 60% discount on all Office visit charges and a 50% discount on labs and procedures (Ultrasound, Bone Density, etc..). **Payment will be expected on date of service. In addition, our office will consider the claim closed and will not file it at any later date.**

____ We attempt to keep our office fully educated on the most recent changes with insurance coverage. However, we cannot know each patient's individual policy. **Patients will need to contact their insurance providers directly** if there is a question regarding coverage for any procedures performed in our office. **This includes the application, download and removal of the continuous glucose monitoring system (CGMS) as some insurance companies may apply an additional copay for this service**. We will obtain precertification if necessary.

____ Please provide 24-hour notice if you must cancel or reschedule an appointment. If we are not given this adequate amount of time**, a $25.00 NO SHOW fee will be charged to your account and must be paid prior to your next appointment**. If a patient acquires 3 "NO SHOWS", they will be subject to dismissal from the practice.

Name Birthdate Date

____ Any patient who comes into the office **(without an appointment)** requesting to see a member of our clinical staff **may incur a $30.00 minimal office visit charge billed to their insurance**. Further, if it is determined that you need to see a physician, physician's assistant or nurse practitioner, a larger fee for an office visit will apply. The patient will be responsible for co-payments, deductibles and coinsurance amounts.

____ We certainly understand that personal health issues can affect your overall sense of wellbeing and as such, might cause a patient to feel very distressed. However, **we will not accept abusive or threatening behavior directed at our staff or providers**. Any such behavior will result in immediate dismissal from this practice. Please address any complaints or concerns in a calm manner to a member of our management team.

____ **ePrescribing** allows your physician the ability to electronically send accurate, error free and understandable prescriptions directly to a pharmacy. By initialing, **you are giving consent** for North Atlanta Endocrinology & Diabetes to request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payors for treatment purposes.

____ There is a fee for all FMLA, school/work, medication and any other miscellaneous forms required by a physician to complete and sign**. Completion of the form will be $25.00 for the first page and $5.00 for each additional page.**

____ A flat fee of $25.00 will need to be collected for any medication that **requires our office to provide a prior authorization** to the patient's insurance company.

___ **Our physicians WILL NOT sign off on medical clearances required by employers. Examples: DOT, pilot, bus driver, etc….**

I have read and fully understand the policies and procedures of North Atlanta Endocrinology & Diabetes and I agree to the terms explained.

Signature of Patient Date

Name Birthdate