DISCLOSURE

PLEASE READ THE FOLLOWING DISCLOSURE CAREFULLY!

All professional services rendered are charged to the patient. We will assist you with insurance reimbursement; however, the patient is responsible for all fees, regardless of insurance coverage. It is our policy to request payment at the time of service, unless arrangements have been made in advance. If you have a question about fees, please check with the receptionist before being seen.

I authorize West Georgia Internal Medicine, P.C., to furnish information to insurance carriers, physicians, or hospitals concerning my illness and treatment. I authorize any physician, hospital, or medical care facility to provide all information on medical history and treatment to West Georgia Internal Medicine, P.C. I assign to West Georgia Internal Medicine, P.C., all insurance payments for medical services including major medical benefits rendered to me. I understand that I am responsible for any amount not covered by assigned insurance. I permit a copy of this authorization to be used in place of the original. I have read all of the above and give West Georgia Internal Medicine, P.C., permission to treat me.

Payment in full, co-payments and/or deductibles, which ever applies, is due at the time services are rendered.

Insurance claims are filed as a courtesy, or as an obligation based on a signed contract with your insurance carrier; however:

Your percentage is due at the time services are rendered
Your deductible must be covered at time of services unless previously met

If your insurance does not pay for their portion after **60 days**, you are responsible for the balance, and you will receive a bill for the balance. In the event that your insurance company does not pay in 60 days and you receive a bill from this facility, it is your responsibility to contact your insurance carrier to correct the problem.

This facility does use the services of a Collection Agency; therefore, if payment is not made on a monthly basis, or no payment is made at all, then your account will be placed with a Collection Agency. In the event legal action becomes necessary, you (the patient) will be responsible for all legal fees associated with your account. In the event checks written for services are returned to our office, there will be a **$25.00** service charge.

Please sign below to indicate that you have read and understand all of the above statements.

_____ _____

Signature of Patient **Date**

Please visit our web site at www.internalmd.com