Financial Responsibility Agreement Form

Please read each line below and sign to acknowledge that you have read and understand our payment policy regarding patient responsibility.

Financial Responsibility

For patients with no insurance coverage, payment is due at time of service. As a self paying patient you will receive a discounted rate on your first visit as long as the payment is made in full on the date of service. If other arrangements have to be made the office visit will not be discounted. We accept cash, checks, and all major credit cards. If you need further assistance please call 706-549-5560 prior to your visit.

As a courtesy to you, we will bill your insurance carrier for all covered services. You will be required to pay all co-payments, deductibles and coinsurances at the time of your visit. All services not paid by your insurance company will become your responsibility. It is the patient’s responsibility to check their own insurance benefits and coverage. If for any reason your insurance company becomes insolvent, any balance is the patient’s responsibility.

As our patient, we will provide the best possible care for you. Services we provide to you may or may not be covered by your insurance due to routine or non-covered, or “deemed medically unnecessary” by your insurance company. In the event your insurance company does not cover your services, you will be responsible. We will make every effort to let you know if we feel your insurance company may not cover your services. As a courtesy, we will obtain pre-certification for any procedures or treatments we schedule for you. Please understand pre-certification does not guarantee payment from your insurance company.

It is the patient’s responsibility to notify us of any change in insurance, mailing address, or contact information.

Cancellation Policy and No Show Policy

It is your responsibility to call within 24 hours of your scheduled appointment time if you need to reschedule your appointment. If you have not called within 24 hours of your appointment or you are a No Show for your appointment, you will be charged a $25 Cancellation/No Show fee. New Patient appointments have a $50 charge for No Show/same day cancellations.

I acknowledge that I have read and understand the above information.

Patient Signature: ___________________________ Date: ____________
I agree that I have been given the opportunity to read and/or receive a copy of Athens Pulmonary Notice of Privacy Practice.

Release of Information: Athens Pulmonary may disclose all or any part of my medical record and/or financial ledger, to any person or corporation (1) which is or may be liable or under contract to Athens Pulmonary for reimbursement for services rendered and (2) any health care provider for continued patient care. Athens Pulmonary may also disclose, on an anonymous basis, any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, status, or regulation.

Patient or Guardian/Beneficiary Print

Patient Date of Birth

Patient or Guardian/Beneficiary Signature

Date
Health and accident insurance policies are a contractual arrangement between an insurance carrier and the insured. It is the responsibility of the insured to verify eligibility for health care benefits. Possession of a medical insurance member ID card is NOT a guarantee of coverage. As a courtesy to you, we will gladly submit your medical bills to your insurance carrier.

1. **Primary Insurance:** I request that payment of authorized benefits be made on my behalf to Athens Pulmonary for services furnished to me by Athens Pulmonary. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE Health Care Financing Administration and its agents any information needed to determine these benefits or the release of medical information necessary to pay the claim. Athens Pulmonary accepts the charge determination of the carrier as the full charge, and I am responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the carrier and are due at the time of service.

2. **Secondary Insurance:** I understand that if other health insurance is indicated my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Athens Pulmonary if possible or otherwise to me, at which time I would forward all payments to Athens Pulmonary.

3. **Release of Information:** Athens Pulmonary may disclose all or any part of my medical record and/or financial ledger, to any person or corporation (1) which is or may be liable or under contract to Athens Pulmonary for reimbursement for services rendered and (2) any health care provider for continued patient care. Athens Pulmonary may also disclose, on an anonymous basis, any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, and medical research, for the collection of statistical data or pursuant to State or Federal Law, status, or regulation.

4. **Non-Covered Services:** I understand that Athens Pulmonary contracts with health care insurance plans. Accordingly, the undersigned accepts full financial responsibility for all items and services which are determined by the health care insurance plan as non-covered services.

5. **Financial Agreement:** I agree that in return for the services provided to me by Athens Pulmonary I will pay my account at the time service is rendered or will make financial arrangements satisfactory to the Athens Pulmonary for payment. If an account is sent to collections, I agree to pay collection expenses. I understand and agree that if my account is delinquent, I may be charged a service fee. Any benefits of any type under any policy of insurance insuring the patient or any other party liable to the patient is hereby assigned to Athens Pulmonary. If co-payments and/or deductibles are designed by my insurance company or health plan, I agree to pay them to Athens Pulmonary. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of the bill.

6. **Divorced Parents:** We do not second party bill. The parent bringing the child to our facility will be responsible for required co-payments, deductibles, etc; at the time of service.

7. **Privacy Plan:** I agree that I have been given the opportunity to read and receive a copy of the Athens Pulmonary Notice of Privacy Practices.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

_________________________________________  _______________________________________
Beneficiary or Guardian Name (print)                                Patient Date of Birth

_________________________________________  _______________________________________
Beneficiary or Guardian ** Signature                               Date

** If an authorization is signed by an individual’s personal representative, the representative’s authority is based on:
_________________________________________ (e.g., state law, court order, etc)