ATHENS OBGYN

Welcome and thank you for choosing Athens Obstetrics and Gynecology. Athens OBGYN is a division of Atlanta Women's Health Group (AWHG) and you will receive your statement from the AWHG Central Billing Office. We are committed to providing you with the highest quality medical care possible in a cost-effective manner. Our professional fees have been determined through careful consideration in addition to being reasonable and customary within our geographical area. We are pleased to discuss with you any questions you may have concerning a bill.

Payment in full is due at the time services are rendered. As a courtesy to our patients, we accept cash, personal check, money order, VISA, MasterCard, Discover and American Express.

VISA MASTERCARD AMEX DISCOVER

THINGS TO BRING WITH YOU TO EACH APPOINTMENT:

- Health Insurance Card(s)
- Drivers License
- Method of Payment

APPOINTMENTS:

Please arrive for your appointment 15 minutes early.

If you are more than 15 minutes late for your appointment, you may be marked as a NO SHOW and may need to reschedule your appointment.

It is your responsibility to verify that the physician is currently under contract with your insurance plan and that you have obtained all necessary referrals BEFORE your scheduled appointment. (Failure to do so may result in your responsibility for ALL charges.)

Please inform the receptionist of any demographic changes in phone number, address, insurance, information, etc. (Failure to notify us immediately of changes in demographic information, financial status and/or insurance coverage may result in you being responsible for payment of any services not covered by your carrier.)

MISSED OR CANCELLED APPOINTMENTS AND OTHER FEES:

24 hour notice is required to cancel and/or reschedule all appointments. Failure to do so may result in a $25.00 NO SHOW fee.

All co-pays are due at the time of service. Any co-pay not received at the time of service may result in a $25.00 processing fee.

There will be a fee of $25.00 for any returned checks to our office.

All balances are due prior to any further service provided by our office.

IN NETWORK VS. OUT OF NETWORK INSURANCE:

Your insurance coverage and benefits are a contract between you and your insurance company, and therefore all disputes must be handled between you and your insurance company.

We are contracted with multiple insurers to accept assignment of benefits.

If you have insurance coverage under a plan with which we do not have a contract, you may be treated as a self-pay patient.

We offer a reasonable discount for our cash paying patients. We will give you an estimate of what will be due at the time of service and payment for services is due at the time of service.

We are required to file with your primary insurance carrier only. As a courtesy, we will file remaining charges to your secondary carrier. It is your responsibility to file charges with any further carriers for reimbursement.

PAYMENT IN FULL IS DUE AT THE TIME SERVICES ARE RENDERED:

Co-pays and co-insurance amounts, deductibles, and all non-covered items and charges are the insured/patient's financial responsibility and are due during the check-in process. Failure to produce payment at check-in may result in your appointment being rescheduled.

If you receive more than one type of service on the same day, you may be responsible for more than one co-payment.

Any amount not covered by the insured/patient's insurance is due within 30 days of the time of service.

As a courtesy to our patients we gladly accept cash, check, money order, VISA, MasterCard, Discover, and American Express.

Failure to pay balances may result in discharge from the practice.

ADDITIONAL PAPERWORK:

Patient paperwork completed by the practice will result in administrative fees.

MINOR PATIENTS:

The parent(s) or guardian(s) accompanying a minor are responsible for providing current insurance information on the minor as well as the payment in full for services provided.

Minors between the ages of 16-18 must have a Pre-Authorization for Medical Treatment Form signed by parent(s) or guardian(s) and on file if a minor arrives unaccompanied for an appointment.

Minors under the age of 16 must have an Authorization for Agent of Proxy to Consent for Medical treatment of a Minor signed by parent(s) or guardian(s) for each visit minor arrives accompanied by Agent or Proxy. Authorization for Agent or Proxy to Consent for Medical Treatment of a Minor can be downloaded from our website at: www.awhg.org.

In compliance with HIPPA regulations, we are unable to discuss any details of services rendered or to produce an itemized bill for any parties that are not the patient, unless otherwise documented.

Both parent(s)/legal guardian(s) are responsible for payment for services rendered to a minor patient.

LAB/HOSPITAL CHARGES:

Any service(s) provided by a lab or hospital is a contract between you and the lab or hospital. Any dispute with that lab or hospital should be handled with that lab or hospital and is not the responsibility of our practice.

It is your responsibility to know which procedures your insurance will and will not cover at these facilities and to request an Explanation of Benefits from your insurance carrier.

Atlanta Women's Health Group uses Phytest as their lab billing company.

Phytest is contracted with our practice to bill and collect lab balances due to our physicians, all correspondence from Phytest are processed under the name of Atlanta Women's Health Group, 2LLC.

REFUNDS:

Refunds are issued to the appropriate party and will be processed approximately 30-60 days from date of the established credit.

Patient refunds will not be processed until all active or past due charges are paid in full.
Refunds less than $50.00 will not be issued, unless requested, and will be credited to your account at our practice.

We contract with Phytest to bill patients for our physician's lab fees, if a patient has a credit with Atlanta Women's Health Group, but a balance with Phytest (or Atlanta Women's Health Group, 2LLC), the patient credit will be utilized to satisfy the lab balance due. Any remaining balance will be refunded to the patient.

By signing this document, I have fully read and understand the financial policy of the Atlanta Women's Health Group. I will cooperate with the billing department of Atlanta Women's Health Group to ensure payment for my services. I understand that I will be responsible for any cost(s) associated with the collection of my account if I default on this agreement. I understand that the terms of this financial policy may be amended at any time without prior notification to me, the patient. In the event that the patient is a minor, I am the parent and/or legal guardian of said patient and agree that I am responsible for payment for all services rendered to patient herein.

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Printed Name of patient/parent/guardian

_____ _____/ _____ /_____

Signature of patient/parent/guardian Month Date Year

Patient Account #: _____