

BULLOCH PEDIATRICS GROUP LLC

CHERYL E PERKINS, MD

PAUL AUSTIN WHITLOCK, MD

MICHELLE ZEANAH, MD

Physician Practice Financial Policy and Release of Information

The following statement is a statement of our Financial Policy for services provided within our office and do not apply to any testing or diagnostic procedure performed outside of this physicians practice. We require you to read and sign this document prior to treatment by this facility.

PATIENT RESPONSIBILITY

All professional services rendered are charged to the patient and are due at the time of services. As a courtesy, this practice will file your claim with your insurance carrier, however the patient or responsible party is ultimately responsible for the charges not covered by your contract with the carrier. Any co-payments or deductible amounts not satisfied with your carrier are due at the time of service.

Insurance carriers typically do not cover all medical costs. Some pay fixed allowances for each procedure and office visit while others pay only a percentage of the cost. Surgical procedures, labs, and any other outpatient procedures may have a higher co-payment of fall under the deductible. It is the patient’s responsibility to understand their insurance coverage. Patients are responsible to know what laboratory your insurance company requires you to use. You will hold Bulloch Pediatrics, LLC harmless in case you receive a bill from a non-covered lab.

When you receive a statement from the Bulloch Pediatrics practice, you are required to pay the balance upon receipt of the statement. If for some reason you do not agree with this balance due amount, you are to contact a billing representative at the phone number noted on the statement. Do not ignore the bill, as it may result in turning the balance to an outside collection agency for recovery and **an additional fee of 33%** will be added to your bill. Non-payment of you bill can result in being discharged from the practice.

Consent/Authorization for Treatment and to Release Information/Disclose Personal Health Information

The signature below serves as authorization for medical treatment by the physician or nurse for the named patient. It also provides authorization for Bulloch Pediatrics LLC to furnish and/or release any information necessary to insurance carriers, third party administrators, self-insured administrator, and/or other health payer representatives in order to process health care claims incurred at this office or for utilization review or quality assurance. This authorization also serves as permission to obtain a copy of you complete medical record from other physician practices or medical facilities. A copy of this authorization may be used in place of the original in obtaining medical records. I understand that I may withdraw this authorization to release medical information at any time, communicate to the practice either in writing or verbally, followed by a written withdrawal.

I understand that I am financially responsible to the Bulloch Pediatrics for any balance not covered by the insurance carrier.

ASSIGNMENT OF BENEFITS

I hereby assign and authorize my insurance benefits to be paid to this Bulloch Pediatrics Practice. I hereby agree that if my bill has been turned over to a third party collection agency for non-payment, there will be a 33% collection fee added to my bill. This is pursuant to Georgia Statutory Law “O.C.G.A.-13-1-11.”

Patient Name (Please Print)

Date

Signature of Patient or Responsible Party

Date