Gastro Consultants of Atlanta, P.C.

Specialists in Digestive and Liver Diseases
Alan M. Fixelle, M.D., F.A.C.G.

OFFICE & FINANCIAL POLICIES

Please read our office & financial policies completely. Please initial each item to attest that you have read and accept the terms. If you have any questions or concerns, please direct them to our Office Manager.

____ I understand that I will be asked to provide my insurance card and picture ID ***at each visit***.
(Our office requires positive identification at every visit for your protection)

____ I understand that it is ***my responsibility*** to understand the rules and terms of my insurance. Gastro Consultants of Atlanta, P.C. accepts and files my insurance as a courtesy and if insurance has not made payment within 90 days the balance will be my responsibility. (We **will not** explain coverage, benefits, or guarantee our participation status in your plan. You need to obtain this information from your insurance carrier via telephone, Internet, or the human resources representative of your employer prior to your visit). If my insurance requires a referral, I understand that it is my responsibility to make sure it is active and provide valid information to the office prior to my appointment or it will be cancelled, and/or I will be responsible for any charges denied as a result of no valid referral.

____ I understand that I am expected to pay co-payments and estimates of unsatisfied deductibles ***at the time of service.*** I will be asked to reschedule my appointment if I cannot pay at this time.

____ I understand that your office accepts cash, check, and most credit cards. I will be charged a $40 service fee for returned checks.

____ I understand that laboratory, pathology, and Anesthesiology bills are separate from our services. All inquiries about these outside invoices must be directed to the service provider or my insurance carrier.

____ I understand that any unpaid balance on my account(s) will be referred to an outside collection agency that will report to the credit bureau and/or resort to further legal action and additional collection fees will be added to my account.

____ I understand that prescription refills are only authorized during ***regular office hours*** and I should allow 24-48 hours for completion. Additional time may be needed if my prescription requires a prior authorization.

____ I understand that when calling the office for scheduling, medical questions/test results, billing information and/or prescription refills I may get a voicemail and when leaving a message I must provide my name, date of birth, callback number and allow up to 24 hours for a return call. I understand making multiple calls and leaving multiple messages may delay the response.

____ I understand that when making appointments for office visits or procedures that if I ***MUST*** reschedule or cancel my appointment that I ***MUST*** give a 24 hour notice. All cancelations with less than 24 hours notice or missed appointments will be charged $75 for office visits and $250 for procedures. I understand that I may be charged a deposit of $200 to reschedule a missed appointment or for appointments that have been rescheduled more than 3 times.

_____ _____
Patient signature Date

Thank you for your cooperation.