Medical Wellness Center

FINANCIAL POLICY

Thank you for choosing Medical Wellness Center of Georgia, LLC. We are honored by your choice and are committed to providing you with the highest quality healthcare. Please read and sign this form to acknowledge your understanding of our patient financial policies.

Insurance: We are pleased to bill your insurance carrier on your behalf. Your responsibility of payment depends upon your particular plan. You are responsible for co-payments, co-insurance, and deductibles at the time services are rendered.

Medicare Patients: Please make certain that you fully understand your benefits and your financial responsibility if your benefits are not covered. Medicare requires a deductible. Supplement coverage may not cover that deductible. If you do not have supplemental coverage, you will be expected to meet pay until it is met. Your co-insurance responsibility will be 20%, due at time services are rendered.

Medicare Supplements: We will only bill your supplement insurance once. If payment is not received in 45 days, any pending balance will be transferred to patient responsibility.

Out of Network: If you have insurance coverage under a plan in which we do not have contract, you will be treated as self-pay (cash-pay) patient and may request documentation to assist you in filing your claim.

Co-pay and Co-insurance: Co-pay, Co-insurance, and/or any balance are expected prior to services rendered.

Deductibles: Some insurance plans require patients to pay a pre-determined dollar amount prior to services rendered.

Additional Charges: You may print your medical records at any time from patient portal. Requests for records in house may incur a charge according state regulations. $35 charge for returned check fees. Any costs associated with collections, legal fees, and/or interest should my account become delinquent.

Payment Responsibility: The Patient, or Guarantor of Financial Responsibility signature below for persons under the age of 18 is responsible for all charges of services rendered. This includes any “non-covered” services. We are happy to assist you in an attempt to “overturn” an adverse determination. However, we will not falsify and/or change a diagnosis or medical documentation. If you are unsure whether a service is covered by your plan, it is your responsibility to call your insurance company to inquire what benefits are allowed.

Prescriptions: Refill and/or new prescriptions that are not requested during the appointment may require an additional visit. This will be determined by the provider at time of request. Approved prescriptions may take up to 24-48 hours. We encourage you to call your pharmacy during those hours as repeated requests may cause delay in processing.

Workman’s Compensation: Charges will be billed to a Workman’s Compensation Center. If claims are denied, you are responsible for all charges.

GUARANTOR OF PATIENT FINANCIAL RESPONSIBILITY

By signing below, I am attesting that I have read, understand, and agree to the provisions provided in this form.

Patient Name: ____ **Date of Birth:** ____________________________

____ ______________________________

Printed Name of Guarantor of Patient or Legal Representative **Date**

____ ______________________________________

Signature of Guarantor of Patient or Legal Representative ***Relation to Patient***

*Address of signer if different than pt:*____

*City*___________________ *State* _____ *Zip Code*_____________ *Phone:* ____________________________