Robert Gadlage and Associates M.D. P.C
3855 Pleasant Hill Rd Suite 420
Duluth Ga 30096
(770) 495-1955

Office / Financial Policy Agreement

Thank you for choosing Robert Gadlage and Associates for your medical care. We are committed to providing you with quality, personal health care, and appreciate your commitment to adhere to this **Office/Financial Policy Agreement.** By understanding our policy, we can provide you with the best service. Agreement with this policy is required for all medical care for the **entire year**. This agreement will be placed in your file for **one year**. Except as indicated below, ***payment is required at the time services are provided*** unless other arrangements have been made in *advance*. We accept cash, personal in-state checks, VISA, MasterCard, Discover and American Express credit cards.

OFFICE HOURS (By Appointment Only):
• Monday-Friday 9:00am to 5:00 pm

As a courtesy to other patients, we request you arrive on time. If you arrive more than 15 minutes late, you may be asked to reschedule. For after hours/weekend **emergencies**, please call the office first. A message will guide you to the Doctor on-Call.

INSURANCE: We participate in most managed care plans and will bill your insurance plan as may be necessary. If we do not participate with your plan, at least 50% is required at the time of service, unless other arrangements have been made in advance. We may be able to bill your plan as a courtesy to you and credit your account if we receive any additional payment.

Knowing your insurance benefits – including eligibility, covered benefits, and medically necessary procedures is *your* responsibility; please contact customer services at your insurance company for questions you may have regarding your coverage. ***You are responsible for any charges not covered by your plan.***

• **Proof of Insurance.** All patients must complete and/or update our Patient Information Form at *each* office visit. You must furnish valid and up-to-date proof of insurance coverage and a copy of your driver's license. **If you provide false or expired insurance information you will be responsible for the balance of the claim. Please notify us of any changes in insurance coverage prior to time of service.** Insurance denials for termination of coverage will be automatically billed to you.
• **Co-payments and deductibles.** All co-payments and unsatisfied deductibles must be paid at the time of service. By contractual law your insurance company requires us to charge for, and you to pay for, all required co-payments, coinsurances, deductible and non-covered services.
• **Claim submission.** We will submit your insurance claims and assist you in any way reasonable to help get your claim paid. Your insurance company may need you to supply information directly to them. It is your responsibility to comply with their request in a timely manner.
• **Referrals.** If your managed care plan requires approval or authorization for referrals to a specialist, radiological imaging, medical facility care, *etc.*, it is *your* responsibility to inform the office of this requirement *prior to* referral.

OUT-OF-NETWORK CARE / SELF PAY: Please be aware that you have an option to seek care from Physicians even though they are not participating in your network. In this situation, your out-of-pocket expense will be greater. We may offer a discount for out of network and self pay patients. This is at the discretion of management.

ADMINISTRATIVE SERVICES, CHARGES AND PATIENT RESPONSIBILITIES: *Due to the continued decline in reimbursements from insurance companies and their failure to pay for the following services, we are no longer able to absorb the cost of these services. Therefore, the following administrative services will be billed directly to you with payment being your responsibility.* Our practice is committed to providing the highest quality of service to our patients while keeping our charges for administrative services at or below the usual and customary charges of other medical practices in our area. All such administrative fees must be paid prior to scheduling future appointments.

• **Missed appointments**. Broken appointments represent not only a cost to us, but also an inability to provide services to others who could have been seen in the time set aside for you. We require 24 hour notice of cancellation to avoid a *$25 cancellation fee.* It is your responsibility to remember your appointment.

• **Letters / Form completion.** At the discretion of the Physician, letters and forms requiring medical review and Physician signature are subject to a **$25** fee. If forms are brought during the time of visit the fee may be waived at the discretion of management.

• **Requests for medical records**. We require written requests for the release of medical records. The medical records will be assessed in accordance to the Georgia Health Information Management Association. Physician to physician will be done as a courtesy.

I have read, understand, and agree to comply with the terms of your Office / Financial Policy.

_____ Date _____

Signature

_____

Printed Name

Robert A. Gadlage MD FACS and Associates, P.C

Release and Use of Confidential Information and Receipt of Notice of Privacy Practices Form

I, _____(Name of Patient), hereby give my consent to Robert A. Gadlage MD FACS and Associates, P.C. to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of _____(Name of Patient).

I acknowledge that I have been made aware that Robert A. Gadlage MD FACS and Associates, P.C has a Privacy Practice in place in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

As a patient of Robert A. Gadlage MD FACS and Associates, P.C, I understand the following:

1. A notice of Privacy Practice is in effect in this office.
2. This policy is made available to me for review via a complete version in a binder that resides in the reception area.
3. I am aware that as a patient I am entitled to a copy if the Notice of Privacy Practice (NPP) if I desire a copy for my personal file.

Upon your review of the above statements, please sign at the bottom acknowledging that you have been advised of the Notice of Privacy Practice (NPP).

Communication Waiver

I understand that as part of my healthcare, Robert A. Gadlage MD FACS and Associates, may need to contact me in order to remind me of an appointment, provide test results, give instructions, or provide other information. I authorize the above to contact me in the following ways (please check those which you authorize):

____Home phone _____Voicemail _____Email
____Work phone _____Voicemail
____Cell phone _____Voicemail _____Email Address

I give permission for Robert A. Gadlage MD FACS and Associates to discuss my information with the following person(s):

Name:_____Relationship:_____

Name:_____Relationship: _____

Robert A. Gadlage MD FACS and Associates, P.C has a secure server and encryption for e-mail communication. However, Robert A. Gadlage MD FACS and Associates, P.C cannot guarantee encryption is on the recipient end and cannot be held liable for such. I understand that I may revoke or modify this agreement at any time. Any revocation or change will not apply to past communications.

Patient Signature:_____ Date: _____

PRINT name: _____ Date:_____