PRACTICE POLICIES
4385 Johns Creek Parkway, Suite 200
Suwanee, GA 30024

We would like to thank you for choosing our practice for your foot and ankle needs. We will do our best to assure that you receive competent, caring service. Below is a list of our general practice policies. These policies are important to run an efficient office and provide the excellent care that you deserve.

APPOINTMENT SCHEDULING:
We ask that you give us at least 24 hours' notice if you need to reschedule your appointment or need to cancel so that another patient can fill that time slot. Although we understand that emergencies do arise, we ask for your cooperation in rescheduling as soon as possible if you cannot keep your appointment.

INSURANCE CLAIMS:
As a courtesy to you, we will submit your insurance claims. Assignment of benefits is to be made payable to our office. However, we ask that you pay your co-pay and deductible (if applicable) at the time of your service. Furthermore, payment is expected the day of service for all self-pay patients.

PAYMENT OF FEES:
Payment of fees for which the patient is responsible is required at the time of service. Checks, credit cards (except Discover) and cash are accepted. There will be a minimum $25 fee for returned checks to cover our bank penalty. You will receive a statement with a detailed description of services, insurance payment and patient responsibility. If not paid, an additional two statements will be sent. At that point, if not paid, you will receive a letter stating that the account will be sent to collections if the balance is not paid. If you are unable to pay in full, we are willing to set-up a payment plan.

AUTHORIZATION TO RELEASE INFORMATION:
In order to file insurance claims, it is necessary to release information to the insurance company regarding the details of your office visit including the diagnosis and treatment performed.

I have read the office policies and hereby agree to the release of information as necessary regarding my treatment. I agree to assign benefits to Ankle & Foot Centers of Georgia so that insurance claims can be filed on my behalf. I also acknowledge my financial responsibility for co-payments, deductibles and non-covered services.

_____ _____
Signature of patient or authorized representative Date

_____
Print Name