Georgia Brain & Spine Center
4355 Johns Creek Parkway, Suite 520
Suwanee, GA 30024

PATIENT FINANCIAL POLICY

Thank you for choosing *Georgia Brain & Spine Center* as your health care provider. We are committed to providing excellent care to all of our patients, and we will always do our best to achieve this goal, whether in the office or at the hospital. As in most medical practices, medical fee reimbursements continue to decrease while our costs continue to increase. We have implemented the Patient Financial Policy to help control costs so that we can always provide high-quality medical care.

We are happy to assist you by billing your insurance company and requesting that your insurance company remit the payments directly to our office. Of course, you are responsible for the annual deductible and any co-insurance requirements at the time of treatment**. _____ (Initial)**

I hereby authorize the direct payment for services rendered to me by Dr. Elias Dagnew to Georgia Brain & Spine, P.C. Regardless of my insurance benefits, if any, I understand that I am financially responsible for any fees of services provided. Please note that all overdue accounts will have a collection fee added. **_____ (Initial)**

I hereby authorize and agree that all future HCFA claim forms will read "signature on file" in box 13 and shall constitute authorization to accept this as a current and valid signature on file for all future claim forms submitted. **_____ (Initial)**

By law, your medical record belongs to the practice. We will forward a copy of your record without charge to another physician if you provide us with the fax number or mailing address. If you would like your own copy of your records, there will be a fee of $25 which must be paid before records are received. Please allow 48 hours to process your request. Should you need a copy of your records for an attorney, they need to request the records directly from our office with your signed consent._____ **(Initial)**

If you should need to request a form to be filled out and the doctor agrees to complete it for you, there will be an additional charge that must be paid at the time of request. (fees may vary depending upon the estimated amount of time it takes to complete it). Please ask our office for the fee upon request._____ **(Initial)**

I have read, understand, and agree to abide by the terms and conditions stated in the Patient Financial Policy. A copy of these policies will be provided to you upon request and the original will remain in your chart for future reference.

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X_____ _____

Patient Signature | Patient Social Security Number

_____ _____

Patient's Name (Printed) | Date