Georgia Foothills Hand Surgery
980 East Main Street, Suite 300
Blue Ridge, GA 30513
Tel: 706-946-7300 Fax: 706-946-7305 Cell: 678-628-8565
Web: www.georgiafoothillshandsurgery.com

Patient Financial Policy

Dr. Worthingstun and his staff are committed to providing you with the best possible care. As such, we are happy to assist you in receiving your maximum allowable insurance benefits. We do request, however, that you are familiar with your insurance plan and that you accept accountability for any balances that are designated as your responsibility. These fees include deductibles, co-insurances, co-pays, and uncovered services.

We participate with most major insurance payers, and will file a claim with your insurance carrier on your behalf. If we do not participate with your insurance plan, you may still choose to be seen by this practice and we will file your claim. Once we have received remittance from your insurance, you will be billed by us for any amount designated "Patient Responsibility" per your contract with your carrier.

Co-Pays and Office Visit fees are due at sign in. If additional fees are incurred after seeing Physician, these additional fees will be paid at check-out. Please assist us by being aware of your insurance benefits prior to your appointment. You ***will*** be charged the full billed amount for any uncovered medical care that you receive. If your plan requires pre-certification or a referral prior to certain services, please let us know. We will work with you to obtain these authorizations from your insurance prior to any scheduled surgical procedure. It must be emphasized, however, that you are ultimately responsible for confirming coverage of any services rendered.

Due to current federal and insurance regulations, any remaining patient balances following claims processing, must be paid within 90 days of receipt of your first statement. We accept payment by cash, check, or credit card. Any balances left outstanding after 90 days will be considered a default of this agreement, and will be transferred to collections for an additional $25.00 fee. Any further fees accrued through further collection attempts will also be charged to your account.

Please sign below to acknowledge that you have read the above policy and that you understand and agree to the outlined terms. There will be a $45.00 returned check fee for insufficient funds. Remember, we are here to help you, and will be happy to answer any questions you may have about your treatment or insurance coverage. We are available at 706-946-7300 Monday through Thursday, from 8:00 am to 4:00 pm, and Fridays 8:00 am to 12:00pm

Please sign and then print your name below:

Signed: _____ Date:___/___/____

Print: _____