Dean D. Worthingstun, DO PC

dba Georgia Foothills Hand Surgery

Office Policy

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal to give you the best possible care. Please read each section carefully, initial, and sign page 3. If you have any questions, do not hesitate to ask a member of our staff.

Appointments

1) We value the time we have set aside to see and treat you for your hand issues. We do not double book appointments. If you are not able to keep an appointment, we would appreciate 24-hour notice. There is a charge of $35 for missed appointments.

2) If you are late for your appointment (>15 minutes), we will do our best to accommodate you. However, on certain days it may be necessary to reschedule your appointment.

3) We strive to minimize any wait time; however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding. Initial______

Forms

1). Disability, Family and Medical Leave Act, work restrictions, school, camp, or sports forms are subject to a $15-per-page fee. Payment is due when the forms are dropped off. We require 5-day turnaround time.
Initial______

Transfer of Records

If you transfer to another physician, we will provide a copy of your record and your last visit to your physician, free of charge, as a courtesy to you. We require 48 hours' notice. You may access your medical records via the patient portal; a username and password are required. For any previous records, you must request them directly from your previous doctor(s). Initial______

Prescription Refills

1) For medication refills, we require 48 hours' notice, during regular business hours. Please plan accordingly. It is the policy of this practice to only honor narcotic (pain) medication orders or refill requests during regular office hours. No controlled substances (pain medications) or refills will be ordered after hours or on weekends. Initial______

Insurance Plans

1) It is your responsibility to keep us updated with your correct insurance information. If the insurance company you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement.

2) It is your responsibility to understand your benefit plan with regard to, for instance, covered services and participating hospitals or therapists.

3) It is your responsibility to know if a written referral or authorization is required to see Dr. Worthingstun, who is a specialist, and whether preauthorization is required prior to a procedure, and what types of services are covered.
Initial______

Financial Responsibility

1) According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.

2) Co-payments are due at the time of service. Out of pocket costs for scheduled elective surgeries must be paid one week prior to surgery.

3) Self-pay patients are expected to pay for services in FULL at the time of the visit.

4) If we do not participate in your insurance plan, payment in full is expected from you at the time of your visit. We will supply you with an invoice that you can submit to your insurance for reimbursement.

5) Patient balances are billed immediately upon receipt of your insurance plan's explanation of benefits. Your remittance is due within 10 business days of your receipt of your bill.

6) If previous arrangements have not been made with our finance office, any balance outstanding longer than 90 days will be forwarded to a collection agency.

7) For scheduled appointments, prior balances must be paid prior to the visit.

8) We accept cash, checks, Visa, MasterCard, and American Express credit and debit.

9) A $45 fee will be charged for any checks returned for insufficient funds. After this situation occurs, we will be unable to accept checks from you in the future. Initial______

Notice of Privacy Practices

This allows us to share health information to carry out treatment, payment and joint health care operations relating to Georgia Foothills Hand Surgery (GFHS), including integrated information system management, health information exchange, financial and billing services, insurance, quality improvement, and risk management activities. I acknowledge that I was provided with a copy of GFHS' Notice of Privacy Practices. Initial______

Patient Agreement and Consent for Treatment

I do hereby voluntarily consent to and authorize medical care encompassing all diagnostic and therapeutic treatments, to obtain pharmaceutical medication history, and the transfer to other facilities considered necessary or advisable in the judgement of the attending physician. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examinations performed in this office. I authorize Dr. Dean D. Worthingstun to treat/retain me and I certify by my signature that I understand and accept the contents of this waiver, except as noted.

I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name____

Responsible Party Member's Name____

Relationship_____________

Responsible Party Member's Signature ___________________________________

Date _________________

On completion, we will provide you with a copy for your records.

Revised 01/01/2023