5329 Memorial Drive Suite A
Stone Mountain Georgia 300083
Phone: 404-296-7695 Fax 404-296- 7695
vistasmed.com

PATIENT FINANCIAL POLICY

1. **INFORMATION:** Patients agree to provide their correct name, current address, contact information, insurance information, Social Security number, driver's license, Passport or picture ID at registration or as requested by the practice at any time.
2. **APPOINTMENTS:** Our office will schedule appointments in consideration of your time. Minors must be accompanied by a parent or guardian to be seen. We require a four (4) hour notice for cancellation as a courtesy to other patients seeking services. A fee of $25.00 will be charged for non-cancelled and missed appointments.
3. **INSURANCE CLAIMS:** Our office will submit insurance claims as a courtesy to you. You are responsible for you bill. You agree to allow our practice to "accept assignment" of benefits and receive payment directly from your insurance company.
4. **INSURANCE COPAYMENTS, CO-INSURANCE AND DEDUCTIBLES:** Insurance companies do not pay all fees and may exclude certain services from coverage. It is the patient's responsibility to understand your insurance plan. All copayments, deductibles and coinsurance and non covered services are to be paid at the time of your office visit
5. **USUAL & CUSTOMARY:** Some Insurance plans may indicate that our fees are above "usual and customary"; As a result your plan may reduce our fee to an "allowed amount" before calculating payment. This practice does not recognize a specific carrier's use of these terms. As such, unless we have specifically contracted with the carrier, it is expected that you will be liable for our full fees.
6. **OUT OF NETWORK:** If you are coming to us out-of-network, by signing this document you are authorizing your insurance company to make all checks payable to Vistas Medical Center. In the event your insurance company sends payment for services rendered in our office directly to you, you agree to endorse the payment to our practice in fulfillment for any amount due within 10 days of postmark.
7. **ACCIDENTS & WORKERS' COMPENSATION:** Vistas Medical Center will gladly treat your medical conditions, if the cause is related to an auto accident or work-related accident you will be required to pay the full fees at the time of the visit.
8. **STATEMENT POLICY:** Our office sends patients statement out on the 15th of every month. Payments are due upon receipt of the statement
9. **EMERGENCIES:** Vistas Medical Center will make every effort to receive your calls and respond promptly in an emergency. If you do not receive an immediate response you should call 911.

10. **PRESCRIPTION REFILLS:** It is our policy that you should know when your medication must be refilled at least a week before you run out. Medications are refilled only if you are an active current patient and have been in the office within 90 days.
11. **MEDICAL RECORDS:** Medical records are the property of Vistas Medical Center, However copies of your pertinent medical information is available upon request. Patients requesting copies of there medical records will have to sign an authorization form and request the records 24 hours in advance. If the patients are requesting medical records to be copied or faxed to another facility there will be a charge of $50.00. Invoice will be sent to the facility prior to medical records being mailed or faxed.
12. **FORMS FEES:** Vistas Medical Center charges for additional paperwork the following fees apply and may change without notice:
    A. Single page forms $25.00
    B. Multiple page forms, FMLA, Immigrations, disability forms $50.00.
    C. Attorneys Disposition $1000.00
13. **PATIENT DISCHARGE:** Vistas Medical Center reserves the right to discharge a patient for any reason. Please note that discharges may occur for failure to meet our obligations under this document. In addition, because of care quality considerations, the practice may discharge you for failure to comply with treatment plans as outlined by your practitioner.
14. **PAYMENT METHODS: We accept Cash, Checks, All Major Credit Cards.**
15. **Return Checks:** All checks returned to the Vistas Medical Center because of insufficient funds, the account was closed, or for any other reason may be subject to the following fees and interest charges: (a) Returned checks in the amount of $25.00 or less will be subject to a $35.00 collection fee and a $35.00 insufficient funds fee. (b) Returned checks greater than $250.00 will be subject to a $100.00 collection fee and a $100.00 insufficient funds fee.

FINANCIAL RESPONSIBILITY: By signing below, you agree to accept financial responsibility for all charges for services rendered to you. If a minor or under guardianship, the parent or guardian accompanying the patient assumes liability.I have read and understand all the terms of this policy and by my signature below, I attest that I fully understand each item and agree to the terms as outlined in Vistas Medical Center Financial PolicyPatient Signature____ Date_________________ Print Name: ____