schilling HEALTHCARE

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SchillingWomensCenter.com
SchillingMedicalSpa.com

Office and Financial Policy

We would like to thank you for choosing Schilling Healthcare as your medical provider. We are pleased and honored that you have chosen us and are committed to providing you with the highest quality healthcare.

Patient Responsibility

1. All co-payments are due at the time of the visit.
2. Co-insurance and unmet deductibles are due prior to services being rendered which includes: office visits, ultrasounds, surgeries and procedures. Once benefits are verified and your estimated financial responsibility is calculated, you will be notified of the payment amount. It is ultimately your responsibility and obligation to be aware of your insurance requirements, coverage's and limitations. We are not responsible for incorrect benefit information given to us by your insurance carrier.
3. You are responsible for all payment of charges for services provided to you from the physicians of Schilling Healthcare.
4. Please understand that you, as the patient, need to respond to any requests from the insurance company for further information. Not responding to such requests will result in claim denial and you will be responsible for payment in full.
5. As a courtesy to you, we will bill your insurance carrier on your behalf. In accordance with your insurance, it is your responsibility to provide accurate insurance information and to present your insurance ID card at every visit. If you do not have insurance or do not present a valid insurance card you will be responsible for payment at the time of service. We are not liable for incorrect information given.
6. It is your responsibility to ensure our physicians are in your insurance network.
7. Payment is due for rendered services 10 days from the receipt of your billing statement. Unpaid previous balances must be paid in full prior to any additional services unless arrangements have been made with our billing department.
8. Pathgroup provides their laboratory services to you in our office. They are not affiliated with Schilling Healthcare and there will be additional charges to your insurance carrier for their services. Any questions about billing from the laboratory are to be resolved by contacting Pathgroup directly at 1-877-456-6706.

Fees

1. Checks are only allowed in extenuating circumstances and must get prior approval. In the event your check is returned, the returned check fee is $30.
2. Medical records requests must be received in writing. Please allow 7-10 business days to process your request. We charge $30 for records which is due prior to record delivery. Fees for medical records are set in accordance with allowable amounts as defined by the State of Georgia.
3. There is a fee of $45 for Administrative Services such as FMLA and/or disability paperwork. These are optional forms and are not related to your medical care and therefore are to be paid by the patient. These forms will not be completed without payment. Please allow 7-10 business days to process your request.
4. There will be an additional charge of 30% of the balance owed for any past due balance that is submitted to an outside agency for collections. Accounts are considered delinquent 90 days from the date the service was rendered.

Billing Disclosures

There may be times when it is necessary for an individual directly involved in your care to call the facility to inquire about your personal health information or billing information. Please take a moment to complete this section.

I authorize Schilling Healthcare to disclose my health information that is directly related to my current treatment to the following individuals listed below for purposes of their role in my treatment or payment for the health services that I have received.

Such persons involved in your care may include: spouse, children, blood relatives, roommates, domestic partners, neighbors and or colleagues.

Name	Relationship
_____	_____
_____	_____

My signature authorizes Schilling Healthcare to file insurance claims on my behalf to all insurance carriers for services rendered and for payments of any benefits due under my insurance plan to be made to Schilling Healthcare when insurance is filed on my behalf. I understand that I am financially responsible for all charges not covered by this assignment. Insurance is filed as a courtesy to the patient.

Signature of Patient	**PRINT NAME**	**Date**
or (Legal Representative) & Relationship to Patient	**PRINT NAME**	**Date**