ATLANTA NEUROLOGY, P.C.
Administrative Services

The goal of Atlanta Neurology is to provide the best medical care possible in a supportive and caring environment. However, many of our services are not covered by insurance. To continue these essential services we have developed a fee schedule which represents the cost of each service to our office. As a courtesy to our valued patients we offer an umbrella benefit which will cover all of these services for a single reduced fee of $97.00. This optional fee is due at the time of your first visit and then annually. If you do not wish to pay the annual fee before requiring any of the listed services, you will be charged for administrative services individually as you request them. **You cannot pay the annual Administrative Services Fee at the time you request these services.** You will again have the option of paying the reduced Administrative Services umbrella fee in one year. Chargeable items you will pay for on an "as requested" basis include, but are not limited to:

Form Completion:

1. Disability forms - $75.00
2. Life insurance forms - $75.00
3. Prior authorization for approval of non-formulary prescription medications - $50.00
4. Family Medical Leave Act (FMLA) forms - $50.00
5. Handicapped parking forms - $25.00
6. Mail order prescription fee - $20.00

Medical Records:

1. Copy of medical records for patient, after first request (requests must be submitted in writing and received in our office **one business week** prior to the date that records are needed) - $35.00 minimum, depending on volume
2. Computer-generated reports (extra claims, statements, payment histories, etc., generally used for flex benefit plans and/ or yearly tax needs) - $20.00

Other (fee to determined at time of request):

Other forms and administrative services that are not a covered service/ benefit under your insurance plan.

☐ *I wish to pay the annual Administrative Services Fee of $97.00 at this time.*

☐ *I choose NOT to pay the annual Administrative Services Fee. I understand that I will pay for the services listed above as I request them.*

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Signature of Patient or Legal Guardian *Date*