



**ATLANTA NEUROLOGY, P.C.**  
**Patient Bill of Responsibilities**

Welcome to Atlanta Neurology. Providing quality care to each of you based on your individual needs and desires is a responsibility we take very seriously. The following are our office policies and procedures. Please read carefully and sign. Also, feel free to ask our office staff if you have any questions.

1. Please keep your scheduled appointments. **The office requires a notice of 24 hours if you are unable to keep your appointment.**

**There will be a \$100 charge billed to your account for appointments cancelled in less than 24 hours or for failure to keep your appointment.** This fee must be paid prior to the next office visit. Frequent no-shows for appointments may result in dismissal from the practice.

2. Medication refill requests will be completed within 24 hours. **Please plan ahead! No refills will be called in after office hours or on weekends.**

The doctor may request to see you before refilling a prescription, and any outstanding balance must be paid before refill requests are completed.

3. Messages received before 2:00 p.m. will be returned the same day. Calls received after 2:00 p.m. may not be returned until the next business day.

Please understand that returning your calls takes time. **Remember to keep your phone with you if you are expecting a return call.** Time does not allow for repeated calls and busy signals; therefore, we will try your phone line twice. If we have to leave a message for you, please be aware that we may not be immediately available when you call back.

4. Atlanta Neurology's billing office will file claims with your insurance company for services provided. **Any charges not covered by your insurance company will be your sole responsibility.**

Please notify us immediately of any changes in your insurance coverage, and **bring your insurance card and a photo ID** with you to each visit.

Due to the large number of insurance plans, it is impossible for our front desk to verify benefits. **It is your responsibility to verify that Atlanta Neurology is a member of your plan before presenting to our office for treatment.** You are also responsible for obtaining a referral from your Primary Care Physician, if required, prior to your scheduled appointment. If you have any questions, please call the customer service number on your insurance card.

5. Co-payments / deductibles / payments for non-covered benefits or services are to be paid at the time of service. We accept cash, checks or credit cards (Visa, MasterCard and Discover). You will be assessed a \$30 fee for returned checks.

Patients electing to be seen out of network will be responsible for payment at the time of service.

6. A \$10.00 service fee will be assessed monthly on account balances that become more than 30 days past due.

In the event that an account is turned over to a collection agency, a collection fee (30% of the balance) will be assessed.

7. Our office collects an annual, optional Administrative Service Fee of \$97.00. This administrative fee is intended to cover the cost of certain administrative services we may provide that are not covered by your insurance. You are not required to pay the Administrative Service Fee; however, if you chose not to pay this fee, you will be charged for all administrative services on an as-needed basis. **A list of our administrative services with associated fees is attached to this Bill of Responsibilities.**
8. In situations of severe financial hardship, we will consider making special payment arrangements on a case-by-case basis. Please discuss this with our billing office immediately if this applies to you.
9. You have a right to be treated with respect and dignity at all times, and to express your opinions, concerns or complaints in a constructive and appropriate manner. Likewise, please treat our office personnel respectfully and courteously.

Thank you for your understanding and cooperation. We are very happy that you have chosen us to provide medical care to you and your family.

*I have read and understand the policies of Atlanta Neurology:*

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*Signature*

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*Date*