E.N.T Associates of South Atlanta

James K. Fortson, M.D.

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Phone: 404-768-9350

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Atlanta, GA 30312
Phone: 404-659-2272

PAYMENT POLICY
Physician / Patient's Agreement

Insurance:
Our office will file your insurance claim to your insurance company as a courtesy. Co-payments are due at sign-in for each office visit and payable by cash or check. Co-insurance (patient's responsible percentage) is due at check out-in for each visit. You are responsible for any service that your insurance company deems as not medically necessary (non-covered), which is due and payable (if known) before services are rendered. If it is discovered that your coverage is not valid the balance due is your responsibility for your account with our office. It is not the responsibility of your insurance company.
Please NOTE: Effective January 1998 under the managed care program, Georgia Law #12-27-4489, "Co-payments are due at the time services are rendered. Failure to make your required co-payment can and will result in the termination of the subscriber's insurance."

Self Pay:
New patients without insurance are subject to pay no less than $150.00 for their initial visit before seeing the doctor. Any balance due will be billed for payment in full within 30 days after service required.

Established patients without insurance are subject to pay the total fee for their follow-up visits up to $100.00 for services rendered by the doctor. Any balances due will be billed for payment in full within 30 days after service rendered.

Returned Checks:
There is a $30.00 service charge for any checks returned by your banking institution. Returned check fees are payable by cash or money order only. Our office will not schedule any appointments until the balance is paid in full.

Patient's Signature:______________________________Date:_____________________________

Guarantor's Signature:_________________________________

PLEASE READ THE FOLLOWING CAREFULLY AND SIGN:

We wish to stress that the financial responsibility for services rendered rests with the patient or his/her family should the insurance company not pay for services for any reason. If your deductible has not been met, you must pay it at the time of service. If your insurance requires co-payment, this will also be expected on the date the service is rendered.

AUTHORISATION TO PAY BENEFITS TO THE PHYSICIANS AND TO RELEASE INFORMATION:

I hereby authorize payment to be made directly to the physicians of ENT Associates of South Atlanta, LLC for medical services rendered.

Signature______________________________________ Date:________________________________

I hereby authorize this practice to release any information regarding my exam or treatment. I have read and understand the above statement. I agree to abide by my insurance carrier's regulations.

Signature______________________________________ Date:________________________________