HYPERBARXS "Your Prescription for Healing"

Your Partners In Healing

HYPERBARIC PHYSICIANS OF GEORGIA

☐ **HyperbaRXs at Kennestone**
61 Whitcher Street,
Suite 2150, Marietta, GA 30060
(Phone) 770-422-4268

☐ **HyperbaRXs at Northside Forsyth**
1505 Northside Boulevard, Suite 1300,
Cumming, GA 30041
(Phone) 770-771-6400

☐ **HyperbaRXs at Saint Joseph's**
5665 Peachtree Dunwoody Road,
Suite G9, Atlanta, GA 30342
(Phone) 678-229-2800

OFFICE USE
Patient Name: _____ MRN: _____

AGREEMENT OF FINANCIAL RESPONSIBILITY

We are pleased to have the opportunity to provide medical services to you. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

- Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards, and pre-approved insurance for which we are a contracted provider.
- All procedures, visits, dressing changes, diagnostic test and facility charges will be filed with your insurance company.

YOU WILL RECEIVE (2) BILLS FOR SERVICES RENDERED:

From the Physician: With Hyperbaric Physicians of Georgia.

From the Facility: Where You Receive Treatment (Listed At The Top Of This Form)

- You will be financially liable for any balances deemed patient responsibility by your insurance company. This includes deductibles, coinsurance and copays.
- It is your responsibility to know your own insurance coverage, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy and any pre-authorization requirements of your insurance company.
- We will check your eligibility with your insurer. We will obtain authorization for treatment from your insurance company when required. It will be your responsibility to maintain benefits throughout your treatment. Please be advised that even with pre-authorization, payment of benefits by your insurance company is not guaranteed. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- Please understand some insurance coverage have Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services that are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In Network rate.

I have read the financial policies outlined above, and my signature below serves as acknowledgment of a clear understating of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

_____ _____
Signature of Patient/Responsible Party Date

_____ _____
Print Patient/Responsible Party Relationship to Patient