MARTHA B. BOONE, M.D., L.L.C.

5445 Meridian Mark Road Suite 120 Atlanta, Georgia 30342

(404) 705-8366 Office (404) 705-8314 Fax

Cancellation / No-Show Policy

In an effort to improve patient satisfaction, we have instituted several policies to help us "run on time". Our office does not over book or double book our appointment slots, which means your appointment time is held just for you. In an effort to honor your time, we have a rigid cancellation policy. We require at least a **48 hours notice for appointment cancellations or you will be charged a $125 fee** that is not reimbursable by any insurance company. To ensure that you do not get billed please notify our office at least 48 hours prior to your appointment.

We have many professional patients and they have told us that it is very important to them that our office tries to run on schedule as much as possible. However, because we do not have control over medical emergencies nor do we always know the nature of most emergencies, it is very hard to do so. But, we believe that your time is as important as ours so we have built a schedule to reflect that. Due to this, please be advised that we will not "bend" on this policy. If you are a patient here, it is a non-negotiable issue.

We place great importance on relationships where there is mutual respect and positive interaction between the staff and our patients. We truly believe that spending quality time with each patient is an integral part of your healing process. Therefore, we sincerely hope that if you find yourself in a situation where you must pay a cancellation fee, you will remember how hard we work everyday to satisfy your needs.

______________________________ ______________________________

Patient Signature *Date*

Financial Policy

Our goal is to keep your insurance or other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner, we ask that you adhere to the following guidelines:

1. **You are ultimately responsible for payment of charges for services you receive from our office.** Certain procedures are non-covered services under all insurance policies; therefore, payment is expected at the time of service.
2. It is your responsibility to provide us with your current address, telephone number, social security number and insurance information at each visit.
3. It is your responsibility to contact your insurance carrier to confirm that the doctor you are seeing is a participant of your plan
4. We will mail you a monthly statement for any outstanding balances. If this balance should proceed to collections **you will be responsible for the 27% collection fee.** If your insurance carrier has not paid the claim within 30 days of the date of service, please contact your carrier and assist us in getting the claim paid.
5. We will only file insurance up to 3 months per claim. At that time, payment is due in full by the patient.
6. **Please provide a Credit Card for payment on your outstanding balance.**

a. **MC Visa** (circle one) **Name on card**:____________________________________

b. **Card Number**:_____________________________ **Expiration Date**:_____________________

c. I authorize Dr. Martha Boone to charge my credit card with the balance on account unless payment arrangements are made prior to the visit. A receipt will be mailed to your address on file. This financial policy will be placed in a locked secure place to prevent unauthorized use of your confidential information.

7. **At the time of your visit, please be prepared to pay your co-payment, co-insurance and any unpaid deductible required by your insurance carrier.**

______________________________ ______________________________

Patient Signature *Date*

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Authorization to Disclose Medical Information

This authorization permits Martha B. Boone, MD LLC to disclose my protected health information to the following third party or parties: (Relatives and/or friends)

1.______________________________ 2. ______________________________ 3. ______________________________

Specify relationship to third party:

1.______________________________ 2. ______________________________ 3. ______________________________

Please read and initial the following statements:

______ I understand that the information disclosed may be further disclosed by the above-named third party or parties and it may no longer be protected by the Final Privacy Rule.

_____ I understand that I may revoke this authorization in writing to Martha B. Boone, M.D. LLC, Attention Chief Privacy Officer at 5445 Meridian Mark Road, Suite 120 Atlanta, Georgia 30342.

_____ I understand that I have the right to refuse to sign this authorization and that my treatment, payment for my health care, and health care benefits will not be affected if I do not sign this form.

____ _______________________________________

Patient Signature *Date*

Release of Medical Records

Martha B. Boone, MD LLC charges fees as designated by the State of Georgia for medical records copying charges, including the cost of supplies, labor, and postage.

Please follow these steps to ensure the successful and timely completion of your medical records:

- Complete the Authorization to Release Medical Records Form or submit a written request.
- Please allow 10 business days for completion.
- Please remember, the request will be completed after we receive your payment. We encourage you to submit your request as soon as possible
- If you have been sent to Dr. Boone by another physician, she will send a “summary letter” of your care to that doctor.
- Dr. Boone is available to speak to any doctor at anytime (unless she is out-of-town, or in surgery) about any emergency condition that you might have.
- As a courtesy, we will fax your records without charge to you referral doctor, one time after the date of service. If you require your records to go to more than your referral doctor, then processing fees will apply.

____ _______________________________________

Patient Signature *Date*