RIVERDALE
1807 Highway 138 SW
Riverdale, GA 30296
(770) 997-7000
Fax: (770) 996-0497

ABSOLUTE HEALTHCARE & REHAB CENTER

MCDONOUGH
902 Pavilion Court
McDonough, GA 30253
(678) 583-9583
Fax: (678) 583-1083

Patient Financial Policy

TO ALL PATIENTS: Please read the following and initial, indicating that you understand them.

_____I have obtained an attorney or will obtain an attorney within 48 hours.
_____I understand that I am responsible for my bill even if I do not receive a settlement.
_____I understand that I am responsible for my bill if my attorney drops my case.
_____I understand that I am responsible for my bill if I drop my attorney.
_____I agree to provide any and all information on my case to the office as it is received.
_____I agree to provide any changes in information to the office. (Address, phone number, etc.)

TO ALL PATIENTS: Please understand that we do bill your insurance.

*** If you have Med Pay under your insurance policy we obtain the right to bill them for our services.**

- If the accident was not your fault, your auto insurance cannot raise and/or cancel your insurance.
- Med Pay is an optional coverage. If you have it, your paying for it, use it.
- By using your Med Pay a portion of your bill here with our office will be paid.
- Why is that a good thing? When you get your settlement most likely your bill with us would have been paid whatever limit your policy allows. (In some cases it is completely paid in full.)

*** If you have health insurance we obtain the right to bill them also.**

- We bill your health insurance for the same reasons we bill your Med Pay.
- If you are working with an attorney you are not responsible for paying your deductible or co-pays to us up front. We hold your bill until your case settles.
- You are only immediately responsible for these things if your case is dismissed or you are no longer being represented by your attorney.
- Your insurance should pay the percentage allowed according to your policy. (70 to 80 percent in most cases.)
- Again, if you have it, your paying for it, use it.

***Payment Options**

- **We will hold the remainder of your bill until your case settles.**
- If you are responsible for making payments towards your bill at the end of your treatment we have the options of accepting.
    - Cash, Check, and credit cards.

***Patient's or Authorized Person's Signature**

I authorize the release of any medical or other information necessary to process this claim. I authorize payment of medical benefits to the undersigned physician or supplier for services described below. I also request payment of government benefits either to myself or the party who accepts assignment below.

SIGNED_____ DATE_____

PRINT NAME_____