

MERINDA HERRON, M.D., PC

699-B PIEDMONT AVENUE, NE

SUITE 1

ATLANTA, GA 30308

NOTICE OF PRIVACY PRACTICES

Thank you for choosing us as your health provider. We are committed to your successful treatment. The following is a statement of Our Office Policy which we require you to read and sign prior to treatment. All patients must complete our patient information form and have their insurance verified before being treated.

PAYMENT METHODS

Initials

We accept cash, checks, money order, debit and credit cards.

RETURNED CHECKS

Initials

There is a returned check fee of \$30.00 in addition to a cash equivalent to the amount of the returned check. We do not deposit checks a second time. We will not accept another check as payment for a returned check.

REGARDING INSURANCE

Initials

As a courtesy to you, we will file your insurance claim at no extra charge. By signing our company policy, you are authorizing your insurance company to send the payment to us. In the event that your insurance company will not send the payments to us, you will be asked to pay for services in full.

Notification of insurance, phone number, address and job changes is your responsibility. Please see our Scheduling Coordinator to update any of the above information.

COLLECTIONS

Initials

All fees associated with collection agencies, attorneys, and court costs will be the responsibility of the patient or the guarantor of the patient.

MISSED OR BROKEN APPOINTMENTS

Initials

You will be assessed a \$20.00 fee for a broken appointment. A missed/broken appointment is defined as the failure to show up for an appointment or failing to call our office within 24 hours prior to your scheduled appointment.

Thank you for understanding our Office Policy. Please let us know if you have any questions or concerns

Signed: _____
By signing, you are agreeing to accept and adhere to the above policy.

Date _____