



We hope to make your visit in our office as thorough and pleasant as possible.

We also want you to have a clear understanding of your insurance plan, our financial policies, and payment expectations.

Please review this policy carefully.

INSURED PATIENTS

Payment is due at the time services are rendered. This includes outstanding balances, deductibles, copayments, coinsurance, expected charges for services rendered during your visit, and other fees for services not covered by your insurance company.

- **Your payment at check-in is based on your expected patient responsibility.** Additional charges may also be collected at check-out or billed after your insurance company processes the claim. You will subsequently receive an Explanation of Benefits from your insurance company and, if needed, statements from Gwinnett Clinic for any remaining balance.
- **If you are unsure what your insurance covers, PLEASE CALL YOUR INSURANCE COMPANY DIRECTLY.** Gwinnett Clinic can provide only general cost estimates, and verification of benefits is not a guarantee of coverage or payment.
- Gwinnett Clinic assists with filing insurance claims, completing insurance forms, and requesting insurance pre-certifications as appropriate.
- **The ULTIMATE RESPONSIBILITY for following up on your insurance claim and paying amounts determined to be your responsibility remains with you.** If your insurance company has not processed its portion within ninety (90) days of being billed, please continue contacting the insurer and Gwinnett Clinic as needed.
- You will receive regular statements requesting payment of any unpaid balance. After two (2) statements, your balance may be forwarded to a third-party collection agency.

PRIVATE PAY / SELF-PAY

Gwinnett Clinic will collect full payment at the time of your visit for services rendered during the visit. You may request a Good Faith Estimate of expected charges at any time before your scheduled services.

- At check-in, an office visit fee, along with payment for all previously unpaid balances, is collected.
- After seeing the physician or Advanced Practice Provider (APP), there may be additional charges at check-out depending on the level of service provided and any additional services, such as laboratory testing or imaging, ordered or rendered during the visit.
- If additional tests are ordered that must be completed after your visit and you anticipate difficulty paying for them, please notify your health care team before leaving the office.

ALL PATIENTS

NO-SHOW FEES		FORM FEES	
Effective for appointments on or after November 1, 2026: Appointments not canceled at least 24 hours in advance may be subject to the following no-show fee:*		Administrative form fees may apply for forms completed by your physician or Advanced Practice Provider beyond standard clinical documentation.	
Primary Care	\$50	Adoption Forms	\$200
Allergy	\$25	Disability Parking Certification Form	\$25
Neurology	\$100	Nursing School / College Admission Forms	\$25
Orthopedic	\$50	FMLA Forms	\$100
Physical Therapy	\$50	Sports Physical Form	\$30
Radiology	\$50	Other Forms	\$20/page

***No-show fees may be adjusted or waived at the discretion of the Medical Director.**

RETURNED CHECK FEE: \$30 (Applies to any check returned by the bank. Additional actual bank fees may apply.)

FEE EXCEPTIONS: No-show and form fees do not apply to Georgia Medicaid patients or where otherwise prohibited by applicable law or government payer requirements.

QUESTIONS ABOUT THIS POLICY: If you have questions about this policy or how it applies to your situation, please contact Patient Financial Services at (678) 889-5285.

Financial Policy Acknowledgment

I acknowledge that I have received and reviewed the financial policies above. I understand that I am responsible for amounts properly determined to be my responsibility under these policies, my health plan (if applicable), and applicable law. If I am signing as the patient's guarantor, I understand that I am financially responsible for amounts properly determined to be due from the guarantor under this policy. I understand that no-show and form fees may apply as outlined above. I understand that I may request a copy of this policy.

PRINTED NAME OF
PATIENT OR GUARANTOR _____

SIGNATURE _____

RELATIONSHIP TO THE
PATIENT (IF APPLICABLE) _____

DATE _____