Georgia Foothills Hand Surgery
980 East Main Street, Suite 300
Blue Ridge, GA 30513
Tel: 706-946-7300 Fax: 706-946-7305 Cell: 678-628-8565
Web: www.georgiafoothillshandsurgery.com

Patient Agreement and Consent for Treatment Payment for Service:

Payment is required at the time of service. We accept cash, check, VISA, MasterCard, and AMEX, or your bank checking card. If you must pay more than your co-pay for your scheduled surgical procedure, payment is expected at the time of service. We are unable to bill you for your office visit co-pay and are unable to process our claim for your visit without having collected your co-pay. Therefore, all co-payments will be collected at check-in.

24 Hour Cancelation and No Show Policy:

There will be a $35.00 charge for any appointments not cancelled 24 hours before their appointment time. After two no show appointments not cancelled by the patient, a charge of $35.00 will be assessed prior to any appointment being scheduled.

Treatment of Minors:

This practice will treat children of all ages for injuries and illnesses, provided the child is accompanied by a parent or legal guardian. (No exceptions.)

Courtesy of Filing Claims:

As a courtesy, we will file your insurance. Filing your insurance is not a means of payment and does not preclude you from paying your co-payment or your co-insurance today. Should your insurance company deem all or part of our charges for your care today, "non-payable", you will be responsible for payment on those charges.

Negotiating of Claims:

We do not accept responsibility for negotiating claims with your insurance company or any other persons. We will however, do whatever possible to assist in payment. If a claim remains outstanding for 60+ days, the balance will be transferred to patient responsibility. You are responsible for payment of your medical care within a reasonable time regardless of the status of claim. Reduction or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred.

Returned Checks for Insufficient Funds Fee:

Please be aware that we will be forced to charge you a $45.00 fee for any checks returned to our offices for Insufficient Funds. After this situation occurs we will be unable to accept checks from you in the future.

*Controlled Substances (Pain Medication) Order/Refill Requests:

It is the policy of this practice to only honor narcotic (pain) medication orders or refill requests during regular office hours. No controlled substances (pain medications) or refills will be ordered after hours or on weekends._____ (initials)

Consent for Medical Treatment:

I, the undersigned, as the patient (or patient's duly authorized representative) do hereby voluntarily consent to and authorize medical care encompassing all diagnostic and therapeutic treatments, to obtain pharmaceutical medication history, and the transfer to other facilities considered necessary or advisable in the judgment of the attending physician. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examinations performed in this office. I authorize Dr. Dean D. Worthingstun to treat/retain me and I certify by my signature that I understand and accept the contents of this waiver, except as noted.

Name: _____ Signature: _____ Date: ___/___/____

Revised 04/06/17