Diplomat of American
Board of Obstetrics – Gynecology

Fellow of American
College of Obstetrics – Gynecology

Wendy Giles, M.D., P.A.
140 Vann Street
Suite 310
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678-401-2403

PAYMENT POLICY AND AUTHORIZATION

Patients who do not carry any form of medical or surgical insurance should know that all services furnished are charged directly to the patient, and that he or she is responsible for payment at the time of service unless otherwise handled. We will submit all medical claims to your insurance company. In these cases, you are responsible for any co-payments, co-insurances, and/or deductibles at the time of service.

In addition to the charge for the visit and/or procedure, if you have laboratory procedures (ie: pap, biopsy, pathology, culture swab) taken; we will submit to your insurance coverage information to the laboratory and you will be billed accordingly to your benefit package. You will receive an additional billing statement from the laboratory for these services. It is your responsibility to obtain your laboratory coverage on both routine and diagnostic labs, prior to services being rendered.

Our office reserves the right to charge a $25.00 NO Show/No Cancellation Fee to patients who fail to cancel appointments in a timely fashion, 24 hour notice. A $50.00 NO SHOW FEE/ NO CANCELLATION will be applies for ultrasounds. This fee will be billed directly to you and is not reimbursable by insurance.

If it becomes necessary to refer your account to an outside collections agency, a 33% service fee will be added to your account.

AGREEMENT AND AUTHORIZATION

I have read, understand and agree to the above policy. I understand that all charges not covered by my insurance company, as well as payments and deductible, are my financial responsibility.

I authorize my insurance benefits for assignment and/or payment directly to Dr. Wendy Giles. I further authorize Dr. Wendy Giles to release any medical or other information to my insurance company and physicians participating in the continuity of my care.

Patient/Legal Guardian Signature	Patient Name/Legal Guardian Printed	Date