TRANSFORMATION
WELLNESS TEAM

678-352-1948
RECEPTION.TWT@GMAIL.COM
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WELCOME TO OUR OFFICE!

We would like to make your visits pleasant and successful. Therefore, if you have any questions regarding treatments, financial arrangements, or scheduling of appointments, please feel free to ask. We are here to help!

There are several payment alternatives available. Please check the payment plan that applies to you listed below.

_______ **INSURANCE-** I am covered by an insurance policy and will be responsible for paying my co-insurance/co-pay portion on a daily or weekly basis. Also, the deductible and any portion not paid by my insurance company will be my responsibility.

PRIMARY INSURANCE INFORMATION: Policy Holder Information	
Name of Primary Insurance Company	**Name of Insured**
Relationship to patient	**Insured Date of Birth**

If you have insurance, we will need to make a copy of your card and have you complete and sign an assignment of benefits form for our records.

I UNDERSTAND THAT ALL CHARGES NOT COVERED BY INSURANCE, REGARDLESS OF THE REASON, ARE MY FULL RESPONSIBILITY.

_______ **AUTO ACCIDENT, WORKER'S COMPENSATION, OR SLIP AND FALL-** (other party responsible) This usually covers your medical bills at 100%. Please supply the front desk with the complete mailing address of the party responsible for the charges. For auto cases, please be aware that should your medical payment benefits become exhausted, you will be responsible for any unpaid charges. Also, as in all cases, if we agree to wait for settlement, you will be responsible to make sure that this office does receive payment for services rendered at the time settlement is made. In the unlikely event that a problem arises with the settlement, you will agree to make arrangements for full payment to this office.

_______ **PCD -** Discount plan that you will be guaranteed to save 25% off your services fee on **EVERY** visit. For more information; please contact our office.

_______ **MEDICARE-** Please be aware that we are a participating provider with Medicare. This means that we will submit the claims to Medicare for you; however, you will be responsible to pay for your co-pay (unless you have supplemental insurance that will pay). **Also, please note that Medicare does not pay for x rays, examinations, therapies, or maintenance care.**

_______ **NONE OF THE ABOVE-** If none of the above applies to you please ask for a consultation with one of the assistants before seeing the doctor.

Returned checks and balances over 30 days may be subject to additional collection fees and interest charges of 1.5% per month.

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Signature Date