WILLIAM F. THORNELOE, MD DLFAPA
4015 SOUTH COBB DR., #270
SMYRNA, GA 30080
PHONE: 770-434-0677
FAX: 770-434-3911

Financial and Scheduling Policies

FINANCIAL POLICY: PAYMENT IS EXPECTED AT THE TIME SERVICE IS RENDERED:
IN THE EVENT THAT YOUR ACCOUNT BECOMES DELINQUENT AND IT BECOMES NECESSARY TO COLLECT THE BALANCE THROUGH THE SERVICES OF A COLLECTION AGENCY, YOU WILL BE HELD LIABLE FOR YOUR DELINQUENT BALANCE, PLUS AN ADDITIONAL **50%** OF THAT BALANCE.

Non-Clinical Services - such as Prior Authorizations, Disability Forms, FMLA forms or other special work - are not billable to your insurance company and require your direct payment. Prior Authorization calls, faxes, emails and letters cost $50 due to the prolonged telephone and professional time. Other forms cost $20 per sheet.

Personal Guarantee of payment: IN CASE ANY OF THE ABOVE NAMED INDIVIDUALS OR COMPANIES FAIL TO MAKE PAYMENT, I HEREBY GIVE MY PERSONAL GUARANTEE OF PAYMENT FOR ALL CHARGES INCURRED.

SIGNATURE_____DATE:_____

LATE CANCELLATION POLICY:
If you need to cancel your appointment, please call 1 business day prior to your appointment. If you are unable to notify us, there will be a $120.00 charge for the late cancellation. More than two missed appointments may result in dismissal from this practice. Thank you for your help to avoid keeping others on our waiting list from missing their opportunity for care.

A Credit Card number is required to pay for missed appointments or late rescheduling. No appointments will be rescheduled without such payment.

Credit Card Number_____ Exp._____

I authorize any holder of medical or other information about me to release to my insurance company or the Center to Medicare/Medicaid Services any information needed for this or other claim. I permit a copy of this authorization to be used in place of the original. I authorize payment of benefits of this commercial insurance or CMS to William F Thorneloe, MD

SIGNATURE_____ DATE_____