

SOUTH FORSYTH FAMILY MEDICINE AND
PEDIATRICS

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The physicians and staff at South Forsyth Family Medicine and Pediatrics strive to provide the best care for your family. Please read the financial, test results and referral policy below. If you have any questions, please contact the front office staff.

1. Please contact us within 24 hours if you need to cancel an appointment. If you miss your appointment without calling ahead of time, you may be charged a \$25.00 no-show fee.
2. We will make every effort to file the charges through your insurance company. Please note some charges may not be covered through your insurance and you are ultimately responsible for these charges.
3. All co-payments are due at the time of service. If for any reason you are billed, our office retains the right to charge an additional fee up to \$20.00 per occurrence.
4. There is a \$25.00 fee for all checks not honored by your bank.
5. It your responsibility to confirm you insurance is valid and that our physicians are covered on your plan.
6. It is your responsibility to contact us with any changes of address, phone number, or change of insurance.
7. Certain services will be charged an additional fee including but not limited to disability, life insurance forms, chart copying and adoption forms. There is no charge for school/camp physical forms when accompanied by an office visit. If you have a question about the cost on a particular form, please contact our front office staff.

Test result policy

It is policy to contact you as soon as possible by phone or mail for all lab and test results, even normal results. If you have not been contacted within two weeks, please call our office to obtain the results.

Referral policy

It is our policy to obtain referrals as soon as possible. If you do not receive notification for a routine referral within 10 business days, please call the office.

I have read the financial, referral and test result statement above and accept the conditions listed above.

Patient Name: _____

Patient Signature: _____

Guarantor's Signature (person who is financially responsible if patient is a minor or person financially responsible for the above listed patient)
