MICHAEL W. BAIN MD
Board Certified Adult, Child & Adolescent Psychiatry
Piedmont Center 3525 Piedmont Road NE, Bldg 6, Suite 210
Atlanta, GA 30305
(404) 261-8291 office (404) 261-5107 fax (770) 396-0496 business office

CONFIDENTIAL PATIENT INFORMATION SHEET

Date:_____ Referred by:_____

PATIENT: _____

SSN#: _____-____-_____ Date of Birth: _____ Age:_____

Address: _____

City: _____ State:_____ ZIP:_____

Home Ph:_____ Work Ph: _____ Cell: _____

PERSON RESPONSIBLE FOR PAYMENT: _____

SSN#: _____-____-_____ Relationship to Patient: _____

Address: _____

City: _____ State:_____ ZIP:_____

Home Ph:_____ Work Ph: _____ Cell: _____

PLEASE READ AND SIGN BELOW

I give my permission for Dr. Bain to treat me or the minor child identified on this page.

I agree that I am responsible for all charges incurred for treatment. I understand that payment is due upon receipt of my statement, that a finance charge of 18% APR will be assessed on any account balance over 45 days from date of invoice, and that I will be responsible all costs required to collect an outstanding debt in addition to any outstanding charges.

I understand that I may be charged for additional services requested outside of appointment times such as phone-in prescription refills, telephone calls to patient, family members, attorneys or counselors, for time spent in completing insurance forms or reports. *I understand that I may be billed for missed appointments or appointments not cancelled at least 24 hours in advance.*

Patient/Parent or Guardian: _____ Date:_____

Printed Name: _____

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All payments should be mailed to:
M.W. Bain MD
PO Box 88423
Atlanta, GA 30356

PATIENT INFORMATION
OFFICE POLICY

Cancellation Policy

A full charge is made for appointments cancelled less than 24 hours in advance.

If you are unable to keep an appointment, please call my office phone **(404) 261-8291** at least 24 hours in advance. You will be charged for any appointment if you do not cancel or reschedule at least 24 hours in advance.

Payments

You will be billed for services at the end of each month. **Payment is due upon receipt of your statement.** Payment may be made by check, payable to Michael W. Bain, MD, or by credit card (Mastercard or VISA).

A finance charge of 18% APR will be assessed on any account balance over 45 days from date of my invoice. If I am required to hire an attorney to collect an outstanding debt, you will be required to pay all collection costs in addition to any outstanding charges.

You may be charged for services requested outside appointment times. Prescription refills and medication changes should be handled during your appointment. I reserve the right to charge you for extended telephone calls to the patient/family members/ attorneys/counselors, for time spent filing out insurance or other forms, or for writing reports that may be required by an insurance company or attorney. In legal cases, such as divorce or accident, the person receiving services will be considered responsible for all charges. Accounts cannot be held for an indefinite period of time pending court settlement.

Health Insurance

I do not participate in any insurance plans and do not submit insurance claims. It is your responsibility to understand your insurance policy benefits and submit claims directly to your insurer for payment. I am considered an "out-of-network" provider and my services are designated as 'outpatient mental and nervous care" by most insurers. (You can confirm your coverage and benefits by calling the telephone number on the back of your insurance card or contacting your benefits administrator.)

If my services are covered by your insurer, you should file a claim and include a copy of my monthly statement with your claim. My statement contains all the provider information your insurer needs from me to process your claim.

If you have questions or concerns about your statement, filing an insurance claim, or wish to pay your bill by credit card over the phone, please contact my business office at (770) 396-0496.