

Atlas Orthopaedics
Duncan Wells, M.D., P.C.
100 Stone Forest Drive, Suite 100
Woodstock, GA 30189

FINANCIAL AND CANCELLATION POLICY

Atlas Orthopaedics reserves the right to charge a fee of \$35.00 for appointments that are cancelled without a 24 hour notice. This fee will also be charged when a patient does not show up for their scheduled appointment.

**THIS APPLIES TO ALL PATIENTS INCLUDING WORKERS
COMPENSATION PATIENTS.**

Reminder calls are done on an "As Time Permits" basis by a member of our staff. There is no guarantee that you will receive a reminder call the day before your appointment. ***You are ultimately responsible for remembering your scheduled appointment.***

In addition, if at some point surgery is required, we will work with you to schedule at the most convenient time for you. However, if the surgery is cancelled within five (5) BUSINESS DAYS of your scheduled surgery there will be a \$250.00 fee that will be charged for the cancellation.

It is your responsibility to provide us with your current address, telephone number and insurance information at each visit. In addition, it is your responsibility to contact your insurance carrier to confirm that Dr Wells participates in your plan.

You are ultimately responsible for payment of services rendered from our office. Co-pays, deductibles, balances etc. must be paid prior to seeing Dr Wells or we will have to reschedule your appointment. There is a \$25.00 returned check fee for checks not honored by the bank.

Failure to make payment on your balance within 90 days will automatically result in your account being turned over to collections and an additional fee of 40% of your overall balance will be charged for recovery fees. Once your account has been turned over to a Collection Agency we will no longer be able to provide treatment and or services to you.

Your signature below is required and is proof that you acknowledge the Financial and Cancellation Policy set in place by Atlas Orthopaedics and you will be responsible for payment of a cancelled or no show appointment and/or surgery.

Patient Name: _____ Date: _____

Patient Signature: _____