PERRY INTERNAL MEDICINE
DAVID J. COX, M.D.
1019 Keith Drive, Suite B
Perry, GA 31069

OFFICE POLICIES AND INFORMATION

Office Hours:
MONDAY, - THURSDAY
9:00 AM – 5:00 PM, closed NOON -1:30 PM for lunch
Friday
8:00 – 12:00 PM

After-hours access to our staff is available by calling 478-988-0022 and following the voicemail message instructions.
Effective, January 1, 2013 insurance co-pays are due at sign-in. If you are unable to make your co-payment upon arrival, you may or may not be seen at the physician's discretion.
Effective, January 1, 2013, the "no-show" fee will increase to $35.00. A no-show fee will be charged for all missed appointments unless our office is given 24 hour's notice that you will not be able to make your appointment time. Exceptions to this policy for extenuating circumstances will be made at the physician's discretion.
Any patient who arrives significantly late for their appointment will be charged a no-show fee and rescheduled for a later date. Exceptions to this policy for extenuating circumstances will be made at the physician's discretion.
24-hours' notice is required for all prescription refills.
It is the patient's responsibility to know what his/her health insurance policy will and will not cover. Our physician will provide services and order labs/studies based on what they believe to be medically necessary in order to provide our patients with the best treatment possible, not based upon what the patient's health insurance will cover.
Claims for services provided will be filed with the patient's health insurance company as a courtesy to the patient. Please remember that health insurance is considered a method of reimbursing the patient for fees paid to the doctor and is NOT a substitute for payment. Some health insurance companies pay a fixed allowance for procedures, and others pay a percentage of the charge. It is the patient's responsibility to pay any deductible amount, co-insurance, or any other balance not paid by the patient's insurance company. In order to control the patient's cost of billings, we request that our charges for office visits be paid at the conclusion of each visit unless prior arrangements have been made. All patient accounts that are more than 90 days past-due will be sent to collections and the patient's medical treatment will be terminated. If a patient's account is assigned for collection, the patient will be responsible for all attorneys' fees and any other costs of collection.

By signing below, I hereby authorize David J. Cox, MD to release all information (including HIV, substance abuse, and psychiatric information) which may be found in my health record and is necessary to secure payment. I request that payment of authorized benefits be made on my behalf. I assign the benefits to insurance, major medical benefits and other health benefits to David J. Cox, MD. I understand that this assignment will remain in effect until revoked by me in writing. I agree that a photocopy of assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by my insurance company. I acknowledge that I have read this form carefully and accept all policies outlined within. By signing below, I acknowledge that I fully understand all of my obligations.

PATIENT NAME:_____DATE OF BIRTH:_____

SIGNATURE:_____DATE:_____