Financial Policy Agreement

Welcome to Georgia Healthcare Services Weight Loss Program!
We are committed to providing you with comprehensive weight loss management and care. This document outlines our Financial Policy Agreement which is required to be read and signed prior to any treatment.

1. Payment Responsibility

All patients are responsible for the full payment at the time of service. We accept payments by cash, credit/debit cards, and other pre-approved payment methods. Payment plans may be available for select services and must be approved prior to the commencement of treatment.

2. Insurance

Georgia Healthcare Services does not file insurance claims. It is the patient's responsibility to request a receipt for services, which they can submit to their insurance provider for potential reimbursement. Please note that not all services provided may be covered by your insurance plan, and you should check with your insurer prior to receiving treatment.

3. Cancellation and No-Show Policy

Patients are required to notify the clinic at least 24 hours in advance if they need to reschedule or cancel an appointment. Failure to do so may result in a cancellation fee of $50.00 being charged to your account.

4. Refund Policy

Due to the nature of our services, we do not offer refunds for any treatments provided. Prepaid services that have not been rendered may be eligible for credit towards other services within our clinic. Please discuss any concerns regarding this policy with our staff before payment.

5. Returned Checks

A fee of $35.00 will be charged for any checks returned due to insufficient funds.

6. Outstanding Balance Policy

Patients with an outstanding balance of more than 60 days overdue must make arrangements for payment prior to scheduling or receiving services. Patients with repeated late payments or returned checks may require advance payment for future services.

7. Collection Practices

If your account is overdue and has not been paid within a reasonable amount of time, your balance may be forwarded to a collection agency. You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 15% of the debt, and all costs, and expenses, including reasonable attorney's fees, we incur in such collection efforts.

By signing this agreement, you affirm that you have read, understand, and agree to the Financial Policy of Georgia Healthcare Services Weight Loss Program. You acknowledge full responsibility for the payment of services rendered on your behalf or your dependents.

Patient Name: _____
Patient Signature: _____
Date: _____

Parent/Guardian Name (if applicable): _____
Parent/Guardian Signature (if applicable): _____
Date: _____