Eamon Dutta, M.D.
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AC4Wbilling@gmail.com **p:(404) 343-4162**
http://atlantacenterforwellness.com/

Financial Policy

1). All payments will be made at time of service, via credit card, which will be securely stored on our electronic health record (EHR) system. If special arrangements need to be made (ie: someone other than you pays your bill), please let the office know ASAP. If you cannot use a credit card, a check may be accepted at time of service, if pre-approved. There will be a $40 check cancellation fee, and a $25 late fee for payments not received by the due date. ***Note: Credit cards will be charged at completion of each service and a processing fee of just under 3% will be added to charges.***

2). The late fee policy will be upheld without exception. Payment is also considered late if your credit card is declined and you fail to give the office a new card in time for payment. ***If you are delinquent with payment, a $25 late fee will be assessed after 30 days, and once a month thereafter, until the bill is paid in full.*** **For payment plans, the $25/month fee will be added to the bill each month until the bill is paid in full. This is the charge for carrying a balance.**

Failure to provide 24 hour notice for cancellation of sessions will result in full charge for that session, no matter the reason.

3). PLEASE NOTE: All costs are out of pocket. A super bill can be given in order for you to file for reimbursement per your request.

The fee structure is: $600 per 60-90 minute (initial assessment); $300 for 30 minute follow-up

Special Financial Arrangement (to be evaluated every 3 months):_____

Credit Card Info: Name:_____CC# _____

EXP:_____/_____ CVV_____ Zip Code:_____

Please contact Kim Frey (billing representative) at (678) 984-6722 or AC4Wbilling@gmail.com with any billing questions or concerns. Signing this agreement also acknowledges permission for Kim to handle financial information regarding your care, and for me to communicate with her and/or AC4W, as well as for her or I to communicate with third party payors about your account/services on your behalf. Signing signifies agreement to the financial policy above:

Printed name of client _____Date_____

Printed name of responsible party_____Relationship to client_____

Signature of responsible party _____