Psychiatric Professionals of GEORGIA

Benjamin Akosa M.D.
Vin Nagaraj M.D.
Ana Segarra-Brechtel M.D.
Heerain Shah M.D.

Your Journey to Wellness

PAYMENT POLICY

Psychiatric Professionals of Georgia is committed to providing you with quality care. In order to achieve this result, we must highlight that as your provider, our relationship is with you, not your insurance company. While filing insurance claims is a courtesy, we extend to all our patients, all charges are ultimately your responsibility. It is your responsibility to know your insurance benefits. Please direct any questions concerning your coverage to your insurance company.

Please note:

1. Proof of current, valid insurance must be provided at time of service. If you do not provide this information, you will be considered a self-pay patient and will be required to pay the full charge prior to being seen.
2. We participate in most insurance plans; however, it is your responsibility to check with your plan prior to your visit to make sure we are participating providers.
3. We will gladly file your claims to your health insurance; however, we do not file automobile, general liability, homeowner's or workman's compensation insurance.
4. If you have HMO/POS insurance, it is your responsibility to obtain a referral number from your primary care provider (PCP) prior to being seen. If you fail to obtain this information, the bill will be your responsibility and you will be required to pay the full charge prior to being seen.
5. Payment is due at the time of service. If you are unable to pay your copayment, your appointment will be rescheduled, and you will be billed a rescheduling fee.
6. Failure to receive your statement does not relieve you of your financial obligations
7. It is your responsibility to notify us of any changes in your billing information.
8. We accept cash and most major credit cards. We DO NOT accept CARE CREDIT.
9. Past due accounts are subject to our collections process and dismissal as a patient.
10. A fee will be incurred for the completion of forms, letters; including disability and FMLA. The office staff can inform you of the specific charge.

I have read and understand the above billing policy. I agree to pay for services under the conditions and specifications set forth in this billing policy and acknowledge that I am responsible for payment of all services provided, regardless of insurance coverage.

For more information or any questions regarding your bill please email: Accounts@PsychiatricProfessionals.com.

Patient Name: _____
Signature of Patient/Guardian: _____
Relationship to Patient: _____
Date: _____

October 22, 2020