



OBSTETRICS ♦ GYNECOLOGY ♦ INFERTILITY  
ENDOSCOPIC & ROBOTIC SURGERY

**MICHAEL D. RANDELL, M.D., F.A.C.O.G.**

*Diplomate, American Board of Obstetrics and Gynecology*

2010

Dear Patient:

Thank you for selecting our medical practice. We look forward to providing you with the highest level of comprehensive women's healthcare. Please review this letter carefully. It explains, in general, our policies and procedures regarding how our practice works, and our fee arrangements and billing methods. If you have any questions regarding these terms, please do not hesitate to contact us. Please sign this letter after you have read it.

**1. How We Work.** Dr. Randell is in private, solo practice. In most circumstances, appointments can be made twenty-four hours in advance. Dr. Randell usually sees patients three days a week and operates two days a week. In addition to taking care of patients, Dr. Randell has teaching responsibilities that may require him to be out of the office on days that he is scheduled to see patients or operate. If this happens, our office will contact you to reschedule your appointment or surgery to a mutually convenient time. Dr. Randell will personally perform all surgeries that are scheduled with him. For pregnant women, Dr. Randell tries to deliver each of his patients. However, situations may occur when Dr. Randell is unavailable and the on-call physician will be present.

We believe that the delivery of first-rate healthcare requires that the patient be informed of the results of various tests. If you have not heard from our office within four weeks of your visit regarding test results, please do not hesitate to call us.

**2. Fees.** We generally bill patients for all services performed in the office and in the hospital. If you have insurance, please present your valid insurance card at each visit. As a courtesy, we will bill your insurance company for all covered services. However, you will be responsible for paying all co-pay and deductible amounts at the time services are rendered. In addition, you will be responsible for paying the costs associated with all non-covered services including, without limitation, providing third parties with medical records and information regarding your care as is requested. Robotic surgery, advanced laparoscopic surgery and fertility care may incur additional charges that are not covered by your insurance.

Prior to having surgery or delivering a baby, we will check your insurance benefits and determine an estimate of the amount likely to be your responsibility. Such estimates are not maximum amounts, however, and the actual amount often differs from the estimated amounts. You will be responsible for paying the estimated amount (and any deductible and co-pay amount) and non-covered charges at your preoperative appointment (usually one week before your surgery) or by thirty-six weeks if you are pregnant.

When Dr. Randell treats you via the telephone after hours it is for emergencies only. Therefore, for routine problems that require history, diagnosis and treatment (i.e., calling a new prescription or refill into a pharmacy) the office may charge up to a \$50.00 professional fee (not covered by insurance) to your credit card on file. There is never a charge for labor related calls, OB problems, postoperative problems and urgent medical issues. *Please call 911 or go to the closest emergency room for all life-threatening conditions.*

We also charge for copying medical records and completing forms for your work or school. Fees are set in accordance with Georgia Law and must be paid prior to record delivery or form completion.

There is a \$130.00 administrative service fee charged for all obstetrical patients and all gynecological patients having surgery. This fee will cover verification of insurance benefits, surgical scheduling, coordinating hospital obstetrical services, completion of FMLA forms, completion of return to work forms, writing of letters, and all other administrative matters not covered by insurance.

**3. Billing Statements.** We generally bill patients on a monthly basis. Your bill will include a description of services performed and any payment made by your insurance company on your behalf. You may also receive separate billing statements from the laboratory, hospital, and/or surgical assistants.

Your balance for our practice is due and payable in full immediately upon receipt of your statement. It is our policy with new patients or with existing patients concerning certain matters, to request to have your credit card information on file. You agree to allow us to charge your credit card the outstanding account balance not paid within thirty (30) days of receipt of the invoice or if your invoice is returned to us as undelivered. Additional processing fees will apply. Further, you agree to pay us for any expenses (including legal fees) we incur in connection with the collection of your past due account.

If you should ever have a question about a billing statement or our billing procedure, you should contact us within thirty (30) days of the invoice date; otherwise, the billing statement is acceptable as presented. For your convenience, you can use your credit card to pay your bill over the telephone or online. There will be a \$10.00 convenience fee charged to your credit card.

**4. Cancellations.** Please notify us at least 24 hours in advance if you need to cancel or change your appointment (14 days for surgery). There will be a \$35.00 charge (\$200.00 charge for surgery) automatically billed to your credit card in the event that you do not show up for a scheduled appointment or you cancel or change your appointment less than 24 hours (14 days for surgery) in advance.

**5. Our Commitment.** Dr. Randell regards his relationship with his patients as an inviolable trust based on respect, compassion, and concern for good health. We are proud of our high standard of work, and care how our patients feel about the services we provide. Patient satisfaction and confidence that our practice provides the highest level of care is at the core of our service commitment. If at any time you, as a patient of our practice, do not feel we are living up to this commitment, please notify us promptly.

**I have read, reviewed, and agreed to the terms of this letter.**

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Patient Name (Printed)**