

ATHENS RHEUMATOLOGY CLINIC, LLC

1360 Caduceus Way-Building 200, Suite 102, Watkinsville, GA 30677

Ph # 706 8508322, Fax# 706 8508366

Please initial the following to comply that you have read the statements and are in agreement with them.

\_\_\_\_ I agree to pay \$10 for requesting paper medical records

\_\_\_\_ There will be a \$50.00 charge for completion of FMLA paper work

\_\_\_\_ Pain medications will be discussed during my doctor visit. No new pain medications can be prescribed over the phone

\_\_\_\_ There will be a \$50.00 charge for no show, late show (20 mins). Please notify Clinic 24 hrs in advance to avoid penalty

\_\_\_\_ I will notify clinic of any change in address, insurance, contact number for optimal care

Patient signature \_\_\_\_\_ Date \_\_\_\_\_