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 $10 charge for completion of social security/disability paperwork

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

____ There will be a $25 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/ Printed name/ date

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