

The SEED Center of Atlanta, Inc. Policies

Patient Name: _____ Date: _____

Parent(s) Name: _____

Parents are _____ married _____ divorced
If divorced, is custody shared: yes no

Part of the The SEED Center of Atlanta, Inc. mission is to provide the coordination of services for families with eosinophilic diseases. In order to do so, we ask that you comply with the following guidelines. Please initial on each line, thank you.

_____ All financial agreements are between the patient’s family and the professional provider. The SEED Center does not get involved in the financial arrangements with your providers. As a courtesy, we pass your insurance information to each office. It is the responsible party’s duty to verify coverage and payments.

_____ It is your responsibility to provide each team provider with any legal documentation or divorce decree dictating a specific parent/guardian responsible for primary health coverage.

_____ It is your responsibility to contact your insurance carrier to confirm that each of your team physicians participate on your plan and you understand your insurance benefits and requirements.

_____ If your child has a procedure, you will receive a bill from the physician and the facility, and other providers such as anesthesia, lab, etc.

_____ If you miss your appointment and/or cancel your appointment within 24 hours of your appointment, you may be charged a “No Show” fee from each of your team physicians according to their office policies.

_____ I understand that The SEED Center of Atlanta, Inc. email server does not encrypt emails. All email correspondence that I send and receive from The SEED Center will be transmitted through standard Internet service. I am authorizing The SEED Center to communicate with me via email.

Parent’s Signature: _____ Date: _____

Patient Signature: _____ Date: _____
(if over the age of 18)