The SEED Center of Atlanta, Inc. Policies

Patient Name: _______________________________________ Date:__________

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 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 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 you have 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.

Patient Signature:____________________________________ Date: ____________