PRINT Patient Name:

____

Patient Date of Birth:

________ / ______/ ___________

FINANCIAL & NO SHOW POLICY

Payment in full is required at the time services are rendered. If you are unable to remit payment in full, you may be required to speak with a patient accounts representative to make alternate payment arrangements.

As a courtesy, we will file claims with your primary and secondary insurance (if applicable) providing we have your *Assignment of Benefits* (see below) and **current and accurate** insurance information from you. Payment for services is ultimately the patient's responsibility. **NOT ALL SERVICES ARE A COVERED BENEFIT OF ALL PLANS.** Your insurance coverage is an agreement between you and your insurance company. Some insurance plans have timely filing limits. If the timely filing limit has been exceeded and you failed to provide accurate insurance information, you will be responsible for ALL incurred charges. **ALL** copays are due at the time of service. Presentation of your insurance card will be expected at **each** appointment.

All patients receiving state funded healthcare benefits (ie: Medicaid) are required to provide accurate identification information for the SPECIFIC PLAN for which they are enrolled. **NOT ALL SERVICES ARE A COVERED BENEFIT.** Review your Medicaid manual if you have questions regarding your specific coverage. Presentation of your state issued Medicaid card will be expected at **each** appointment.

As a courtesy, will file claims with your workers compensation carrier or other third party liability carrier(s). All billing information must be provided by the patient in advance and must be **accurate**. Ultimately, all charges are the responsibility of the patient.

If you have questions concerning insurance payment or denial of your claim, you should **first contact your insurance provider** to obtain further information. **ALL BALANCES ARE DUE IN FULL** upon receipt of a mailed statement. If you are unable to remit payment in full, you are required to contact our billing office at 888-342-3689 to speak with a patient accounts representative. Failure to remit payment or correspond with the billing office may result in your account being subject to further collection efforts. Accounts subject to additional collection efforts may result in the responsible billing party and associated family members having medical services suspended and subject to termination from the practice.

Returned checks may be subject to a $30.00 fee per occurrence.

Unless other arrangements have been made and agreed to by the parties in writing, the amount due as reflected on a statement is due when services are rendered. A late payment charge of one and one-third percent (1 1/3%) per month may be charged on any unpaid amounts from and after the 31st day following the date of the statement; provided, however, in the event the patient has health insurance and a claim is submitted, the late payment charges will apply from and after the 61st days following the date the insurance provider has determined what the patient's financial responsibility (e.g., deductible/co-insurance) is for the medical services rendered. In the event the patient's account is sent to a collection agency, the patient (or patient's responsible party, as applicable) agrees to reimburse IMP for the fees charged IMP by such collection agency, which fees may be based upon a percentage not to exceed 33 1/3% of the patient's outstanding account balance, and all other costs and expenses, including reasonable attorneys' fees, IMP incurs in its collection efforts.

No-Show/Late Arrival Policy:
A minimum 2 hour notice is required to cancel appointments. If the required notice is not received, you may be charged a $25.00 fee. This fee is NOT covered by your insurance. If you are more than 10 minutes late for your appointment, you may be required to reschedule.

FINANCIAL AGREEMENT/ASSIGNMENT OF BENEFITS
I have read and agree to the terms and conditions set forth above. I understand that I am responsible for and agree to pay all charges regardless of insurance coverage or pendency of claims. I authorize the release of all medical information necessary to process my health insurance claim and request payment of benefits be made to Internal Medicine Physicians, P.C.. A photocopy of this agreement shall be as valid as the original. I understand that I can withdraw this medical benefit assignment at any time by notifying this office in writing.

Patient or Responsible Party Signature ____ Date ________________