

The Internal Medicine and Pediatric of New Albany's Financial Policy

Patient Name _____ DOB _____

MedRec# _____

Dear Patient and/or Guarantor:

Thank you for choosing us as your health care provider. The following is our Financial Policy. We ask that all patients read and sign our Financial Policy prior to receiving services. Our main concern is that you receive proper and optimal treatment needed to restore your health. **IF YOU HAVE ANY QUESTIONS OR CONCERNS ABOUT OUR PAYMENT POLICIES, PLEASE DO NOT HESITATE TO ASK US ABOUT IT.**

Payment for non-covered services is due at the time services are rendered. I understand that the clinic will set up arrangements for payment of my account if I need this assistance. Cash, Checks, Discover, Visa, MasterCard and American Express are accepted for payment. The clinic also offers automatic bank draft as a payment option. You may also pay your bill online at www.impcna.com.

1. Your insurance policy is a contract between you, your employer, and the insurance company. If you have a personal policy then it is a direct contract between you and your insurance company.
Please initial here _____
2. All charges are your responsibility whether your insurance company pays or not. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
Please initial here _____
3. Coinsurance, co-payments and deductibles, along with all outstanding balances on any account that you are guarantor of are due at the time of service.
Please initial here _____
4. If the insurance company does not pay your balance in full within 30 days, we ask that you contact the carrier to help in processing your payment. If the balance remains unpaid by insurance for 60 days then you will be made responsible for the full amount at that time. Balances at 60 days may be subject to a finance charge.
Please initial here _____
5. If the insurance company does not pay in full within 60 days, we require you to pay the balance due with cash, check, Discover, Visa, MasterCard or American Express.
Please initial here _____
6. Returned checks are subject to a \$25.00 service fee and an immediate referral to an outside collection agency.
Please initial here _____
7. We will refund any credit on your account to you or your insurance company depending on the circumstances. However, if you have another account balance, any credit due to you will be transferred to the account with the balance until all balances are paid in full.
Please initial here _____

The Internal Medicine and Pediatric of New Albany's Financial Policy

Financial Responsibility:

I, the undersigned, jointly and severally, in consideration for the services rendered, accept financial responsibility and agree to pay The Internal Medicine and Pediatric Clinic of New Albany, PLLC for its charges for services rendered to the patient upon receipt of a statement for such charges. The undersigned further agrees that if such indebtedness is placed in the hands of a collector or an attorney for collection, the undersigned will pay attorney fees, interest, court cost and other collections costs and expenses. I also understand that should this account be referred to collections, I, and any family member tied to this account, will be terminated as a patient from The Internal Medicine and Pediatric Clinic of New Albany, PLLC and need to seek medical attention elsewhere. I further authorize any overpayment due me on this account to be applied to any other outstanding balance that I may owe at The Internal Medicine and Pediatric Clinic of New Albany, PLLC.

Responsible Party Signature _____ Date _____

Assignment of Insurance Benefits:

I transfer and assign to The Internal Medicine and Pediatric Clinic of New Albany, PLLC and to any applicable physician, all of my rights to benefits payable to me or to a beneficiary. By this assignment, I authorize payment directly to The Internal Medicine and Pediatric Clinic of New Albany, PLLC and directly to the rendering provider. I understand and agree that if any part of my account is not paid by insurance, for whatever reason, I am still financially responsible for the indebtedness. It is my responsibility to take the action necessary for such benefits to be paid to The Internal Medicine and Pediatric Clinic of New Albany, PLLC or the physician.

Responsible Party Signature _____ Date _____

Medicaid Beneficiaries:

I have read and understand the Medicaid Policy that has been put into effect beginning July 1, 2009 concerning the number of visits per year Medicaid will pay for and the result should I run out of said visits. I understand that Medicaid only pays for 1 provider's services on a calendar day. I understand that I will be held liable for any and all services that are not covered by Medicaid under these circumstances.

Responsible Party Signature _____ Date _____

Valid Identification:

I will provide valid proof of identification to The Internal Medicine and Pediatric Clinic of New Albany, PLLC at the time of service. I understand that The Internal Medicine and Pediatric Clinic of New Albany, PLLC will not share this information with any outside source and uses this information to verify my insurance. I further understand that if I cannot provide valid proof of identification at the time of service, then my appointment will be rescheduled until such proof can be given.

Responsible Party Signature _____ Date _____

Again, thank you for choosing us as your health care provider. We appreciate your trust in us and we appreciate the opportunity to serve you.