Integrative Family Health Associates

Clinic Policies

Patient Name: _____ Date of Birth: _____

Release of Information

All information provided herein is true and correct. I hereby consent to treatment. I give permission to my provider and staff to release information, verbal or written, contained in my medical record and other related information ONLY to related healthcare providers, assignees, and/or beneficiaries and other related persons. I have read and understood this release.

Insurance and Bill Payment Information

1) **Payment is your responsibility**: Knowledge of your insurance policy is very important! We will take a copy of your insurance card when you first come into our office. If there are any changes with your insurance coverage, or if you switch insurance companies, please notify our office. We will submit your insurance claim for you. ***You, however, are responsible to determine whether services provided or to be provided are covered by your insurance.*** Once your claim is submitted to insurance, we are ***unable to change billing or coding to help you get coverage***, so you need to let the doctor know ***ahead of time*** about a high deductible or no coverage for preventive care services. In any event, you are also responsible for your bill, including any deductible and/or copay, and you must pay any balance not paid by insurance within 30 days of billing. Payment is due at the time of service.

2) **Balance to be paid** within 30 days of billing invoice date sent to you. You may call our office and pay with your credit card (we accept Visa MC AmEx and Discover) or you may send a check.

3) **Unpaid Account**: If payment is not obtainable by credit card or check at the time of service, we will charge you 9% interest on any unpaid balance. Any check returned unpaid will be subject to a $30.00 fee. In the event your account must be sent to collection, you will be responsible for any costs and attorney's fees incurred as a result of any collection action taken.

4) **Missed Appointments**: In the event that you cannot make an appointment, please give 24 hours notice. (You may leave messages on our phone appointment mailbox after hours). If you fail to notify us of your intention to miss an appointment, you authorize us to charge your account for the full amount of the appointment visit. You understand that repeatedly missing appointments will cause us to terminate you as a patient. This fee is in addition to and exclusive from any insurance coverage you may have, whether public or private. This fee will be subject to the collection procedures outlined above.

I understand the terms of payment to the office of Integrative Family Health Associates. I authorize payment of medical benefits to my physician. I also consent to the performance of any office procedure or treatment that may be necessary to make an appropriate diagnosis.

Date: _____ Patient or Guardian Signature: _____

Printed Patient Name: _____

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