Internal Medicine Financial Policy

We are dedicated to providing you with the best possible care and service, and regard your understanding of our financial policies as an essential element of your care and treatment. Unless other arrangements have been made in advance by you or your health care carrier, full payment is due at the time of service. For your convenience we accept VISA and MASTERCARD. If you have any questions, please feel free to discuss them with our staff.

Insurance and Patient Payment

We have made prior arrangements with some insurers and other health plans. We will bill those plans with whom we have an agreement, and will collect any copayments and deductibles at the time of service. In the event your health plan determines a service to be "not covered," you will be responsible for the complete charge. In the event we bill you, payment will be due upon receipt of the bill.

If you have insurance coverage with a plan with which we do not have a prior agreement, we will give you the information you need to file a claim. In this case, your insurance will send the payment directly to you. Therefore charges for your care and treatment are due at the time of service.

We will bill your health plan for all services we provide at the hospital. Any balance due is your responsibility, and is due upon receipt of a statement from our office.

Release of Medical Information

I hereby authorize Internal Medicine Associates to release any medical information required in the processing of financial applications for financial coverage for services rendered in the course of my examination and treatment. This authorization shall remain valid until revoked in writing.

HIPPA-Privacy Practice Acknowledgement Form

A copy of Internal Medicine Associates privacy practices has been made available to me.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

Permission for Release of Patient Information

I authorize Internal Medicine Associates to speak to the following individuals regarding my medical information:

Name	Relationship	Financial	Medical
Name	Relationship	Financial	Medical
Name	Relationship	Financial	Medical

Signature of patient or responsible party:_____

Print name of patient:_____

Date: _____