Integrated Medical Group, P.C.

FINANCIAL POLICY

This financial policy contains important information about billing and payment for our professional services. Please read this entire policy in order to prevent any misunderstandings concerning the financial aspects of your medical services.

- Payment is due at the time of service unless prior arrangements have been made.
- If you have health insurance, you are responsible for presenting your current insurance card at the time of every service.
- If IMG participates with your insurance, we will file your claim and accept their approved reimbursement as payment in full for covered services. If IMG does NOT participate with your insurance, we will still file a claim with your insurance company as a courtesy to our patients. All deductibles, co-payments, co-insurance and non-covered services are your responsibility to pay.
    - Please remember: Your insurance is a contract between you and your insurance company. We are not a party to that contract.
- Payment can be made by cash, check, money order, and credit or debit card. We accept Visa, MasterCard and Discover Card.
- If your check is returned for insufficient funds, you will be charged a returned check fee of $30.
- If you request the completion of medical forms, you may be charged a fee of $15.
- If your insurance requires any referrals or authorizations, it is your responsibility to provide them prior to your visit. In the absence of a required authorization or referral, you may be rescheduled or personally responsible for payment.
- A late charge of 1.5% per month or maximum allowable rate may be added for balances over 30 days old.
- If your personal balance is not paid within 90 days, your account may be turned over to a collection agency. In that case, you will be responsible for any and all collection agency fees.

I have read all the information above and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. In the event my insurance company is billed, I authorized payment of medical benefits to be paid directly to INTEGRATED MEDICAL GROUP. A photocopy of this agreement shall be considered effective and valid as original. I understand that any services or procedures not covered by my insurance are my responsibility.

Print patient's name: _____

Print parent/guardian name: _____

Signature: _____ Date: _____