**IMS PRIMARY CARE**

**OFFICE POLICY: EFFECTIVE IMMEDIATELY**

**Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* **Please turn off all cell phones while in the office**.
* No food or drink is allowed in the office with the exception of water.
* All patients/parents/guardians are required to bring their insurance card and photo ID to **EVERY** appointment including lab draws or in-office testing.
* No patients under the age of 18 will be seen in our office without a **written note giving permission to seek medical treatment, and copy of current ID** from the parent or legal guardian.
* In the event a patient is unable to keep their scheduled medical appointment with their provider a phone call must be received by our office **24 hours prior to the appointment time;** otherwise an automatic $25.00 administrative fee may be charged to the patient account.
* We do not bill for co-pays or deductibles unless otherwise stated by the insurance. **PAYMENT IS EXPECTED ON DAY OF SERVICE,** or there will be a $20.00 administrative fee.
* All self-pay accounts will be collected up front: **new patients $176.00 and established patients $121.00**. Any remaining fees will be collected when the patient checks out.
* Should a patient leave a message with our office, they can anticipate a return call within 24 hours.
* No pain medications or routine medications will be called in to the pharmacy by the ON CALL PROVIDER. Patients will need to contact the office during regular business hours.
* Patients will be required to sign a pain management contract for any pain medications prescribed by our providers.
* All patients are responsible for making their follow-up appointments and must arrive on time.
* Any patient that arrives 10 minutes after their scheduled appointment will be asked to reschedule. If the patient must be seen because of an acute illness he/she may have to wait to be seen by another provider after his/her case has been reviewed.
* Walk-in patients will be seen only with the provider’s authorization.
* At no time will medical information be shared with another individual/party unless explicitly specified by the patient. A consent form providing authorization to release medical information must be signed. We also will not release any samples, prescriptions, orders etc. without written consent from patient.
* **This office is not responsible for knowing the patient’s insurance benefits.** Should a diagnostic test and/or procedure be recommended by your provider, but is **NOT** covered by the insurance, the patient will be responsible for **ALL CHARGES.** This also includes charges related to “weight or obesity management”. Patients may be required to sign additional waivers and/or contracts.
* If the medical provider feels that the patient needs further diagnostic work up (x-rays, etc) or refers you to a specialist it is the patient’s responsibility to ensure that those tests and/or office visits are completed.
* **AT NO TIME** will inappropriate behavior by the patient or family members be tolerated while in person or on the phone. Such behavior could justify cause for termination of provider-patient relationship.
* If a patient misses 3 visits within a year IMS Primary Care reserves the right to discontinue the provider- patient relationship. A letter will be sent to the patient to notify of such.

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**have read IMS Primary Care office policy. I will be given a copy if

**PRINT** PATIENT/GUARDIAN NAME) requested only. I agree to follow this policy at all times.

Patient/Guardian **Signature** Date

Staff Witness Date

**Financial Agreement**

Thank you for choosing IMS Primary Care as your health care provider.

We welcome you and are committed to providing quality medical care.

Please carefully read and sign the following statement of our financial policy prior to treatment. Feel free to speak to our staff if you have any questions.

**It is your responsibility to be aware of your insurance benefits.**  Exclusions, pre-existing conditions and terminated benefits may nullify insurance coverage and transfer the financial obligation to the responsible party. You are responsible for payment of any deductibles and co-payments/co-insurance as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. You will be responsible for any amounts not covered by your insurance. If you are unclear of your insurance benefits, you will need to contact your insurance carrier for clarification of coverage.

**Payment is due at the time of service.**  You are responsible for any unpaid balance on your account. Our office accepts cash, Visa, MasterCard, American Express, Discover Card and most debit cards. **WE DO NOT ACCEPT CHECKS.** Finance charges will begin to accrue on any unpaid patient responsibility balance after 90 days old.

**It is your responsibility to notify our office if there is a change in name, insurance coverage, residence and/or phone number.**

**I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** agree to make financial arrangements satisfactory to IMS Primary Care for payment in return for the services provided. If the account is sent to an attorney for collection, I agree to pay reasonable attorney’s fees and collection expense. The amount of the attorney’s fees shall be established by the court and not by a jury in any court action. A delinquent account may be charged interest at the legal rate.

If any signer is entitled to applicable benefits of any type whatsoever under any policy of insurance insuring patient or from another party, the benefits are hereby assigned to IMS Primary Care for application on patient’s bill. However, IT IS UNDERSTOOD THAT THE UNDERSINGED AND PATIENT ARE PRIMARILY RESPONSIBLE FOR PAYMENT OF PATIENT’S BILL.

IN RENDERING TREATMENT, IMS PRIMARY CARE IS RELYING ON THE ABOVE AGREEMENT TO ENSURE PAYMENT OF THE ACCOUNT.

Patient/ Guardian Signature Date of Birth Date

Staff Witness Date

**QUESTIONS, CONCERNS OR COMPLAINTS**

If you have any questions or want more information about this Notice or how to exercise your privacy rights, please contact our

Privacy Officer at 1-888-787-9845 or by mail at 9250 N. 3rd Street, Suite 4010, Phoenix, Arizona 85020

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services (HHS). To file a complaint with us, you may contact our Privacy Officer. To file a complaint with HHS, you may contact the Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Ave. S.W., Room 509F HHH Bldg., Washington DC 20201 ([OCRComplaint@hhs.gov)](mailto:OCRComplaint@hhs.gov). **We will not retaliate against you for filing a complaint.**

Effective Date: September 23, 2013

Signature below is acknowledgment that you have read and understand this Notice.

Patient Name: DOB:

Signature: Date:

**RELEASE OF INFORMATION**

I hereby authorize IMS to release or discuss any and all information pertaining

to myself or my medical records with the following people.

Name: Relationship: Phone Number:

Name: Relationship: Phone Number:

Name: Relationship: Phone Number:

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we leave a message on machine? Yes No

Cell Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Signature: Date:**

Witness: Date: