

FINANCIAL POLICY

Internal Medicine & Pediatrics Associates, PSC
7101 W. Hwy 22
Crestwood, Ky 40014

Phone (502) 241-6567
Fax (502) 241-5083

This is an agreement between Internal Medicine & Pediatric Associates, PSC, as creditor, and the Patient/Debtor named on this form.

In this agreement the words “you,” “your,” and “yours” means the Patient/Debtor. The word “account” means the account that has been established in your name to which charges are made and payments credited. The words “we,” “us,” and “our” refer to Internal Medicine & Pediatric Associates, PSC.

By executing this agreement, you are agreeing to pay for all services that are received.

Monthly statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any, and any payments or credits applied to your account during the month. We will send statements for 3 months. At that point, if there has not been any contact with us, the account will be sent to collections.

Payment options if you have no insurance:

1. You must pay by cash, check, or credit card on the day services are provided.

Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company. The insurance company must pay your claim within forty-five (45) days of submission. If not, the responsibility of payment for the services rendered becomes yours.

COPAYS: The copay amount is set by your insurance company. All co pays MUST be paid at the time of visit. If you do not have the copay, you may be asked to reschedule your appointment. This policy is set by your insurance company.

Patient's name: _____

Signature: _____ **Date:** _____

Co-Signature _____ **Date:** _____

Returned checks: There is a fee (currently \$25) for any checks returned by the bank.

Missed appointment fee: Patients who do not show up on time for an appointment, or cancel with less than 24 hours notice will be charged a \$45 fee. This fee must be paid before a new appointment is scheduled. Patients with three missed appointments will be asked to transfer their records to another doctor.

THE FINANCIAL POLICY CONTINUES ON THE OTHER SIDE OF THIS PAGE

Workers Compensation: We require written approval/authorization by your employer and/or workers compensation carder prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Automobile accidents: We do not file any claims to auto carriers. Payment must be paid at time of visit. The encounter form that is provided to you when you check out, can be given to the automobile carrier for reimbursement to the patient.

Co-signature: If this or another Financial Policy is signed by another person, that co-signature remains in effect until cancelled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in force and effect.

Forms and letters: In the circumstance that you need a form or letter completed, we will complete these for a fee. These fees are posted at the front desk. Completion of these forms do require time, therefore, the physicians are not available to see patients. This fee will be collected at the time the letter is requested, prior to the completion of the form.