Integrated & Preventative Health Care Associates

Financial policies, Informed Consent for Treatment, and HIPPA Consent

Thank you for choosing us as your health care provider. This document is a summary of our financial policies, an explanation of your responsibilities, authorization to bill your insurance on your behalf for services provided to you, and your notice of HIPPA privacy.

You may be responsible for co-payments, deductibles, and services provided which may not be considered a benefit under your policy. Your insurance may deny claims for a variety of reasons.

1. The services provided may not be a benefit of your health insurance policy or may not be covered when provided by our office you may have exhausted your benefit for the services provided.
2. Medical Necessity generally means a determination based upon criteria and guidelines developed by your insurance carrier in consideration of generally accepted standards and practices.

Patient/Responsible Party Agreement

a. If my physician does not participate with my insurance company or my insurance company does not pay for the services provided, or I do not have insurance coverage, I agree to be personally and fully responsible for all payments.
b. I accept responsibility for all co-payments and/or deductibles, and understand that each office visit or procedure is billed as a separate entity, based upon insurance and medical practice protocols.
c. I understand that a statement of my charges and payments will be sent to my mailing address unless I otherwise indicate.
d. I understand that there is a $50.00 fee for returned personal checks.
e. I understand that there is a missed appointment or late notification cancellation charge of $50.00 if I fail to notify the office within 24 business hours of my appointment.
f. I understand that should my account balance go to collections that a 50% collection fee will be assessed, which must be paid along with any outstanding balance before any further services will be rendered by this office. I understand that a return to service is solely at the office's discretion. Additionally any attorney's fee that is incurred by this office in regards to the collection will also be my responsibility.
g. I understand that my health care provider will have access to all of my medication and health history.
h. I am allowing my health care provider to contact me on my cell phone.
i. Medication refill requests will require a minimum of 72 business hours in order to be processed.
   Furthermore, refill requests will only be honored at the physician's discretion, and will not necessarily be fulfilled on a patient request.

j. Prior authorizations and referrals will require a minimum of 5 business days in order to be processed.

Informed Consent for Treatment

Please read the following statement carefully. Your signature indicates agreement with each of the statements listed above and gives us permission to provide services as indicated below.

I authorize my health care provider to provide treatment to my legal dependent or myself. I understand that treatment does not require a mutually agreed upon plan of service and that my participation in this plan is essential. I understand that through the course of treatment, my physician will assist me in understanding procedures, possible risks, and purpose of treatment. I understand that I may withdraw my consent at any time, but I will notify my health care provider of my intent to do so. I furthermore understand that I must comply with the treatment plan in order to receive continued services from the physician.

Notice of Privacy Practices – Patient Acknowledgement

The HIPPA Privacy Notice provides the uses and discloser of my protected health information that may be made by this practice, my rights, and the practices legal duties with respect to my information.

I understand that my health care provider reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information at, or controlled by this practice. If changes to the policy occur, my health care provider will provide me an opportunity to review the Notice of Privacy Practices upon request.