Financial Policy and Patient Consent Form

IKP Family Medicine, P.A. (IKP) recognizes the need for a clear understanding between patient and medical provider regarding protected health information and financial arrangements for healthcare. The following information is provided to avoid any misunderstandings concerning protected health information and payment for professional services.

For the safety and protection of our patients and **IKP**, patients are required to present a valid form of identification upon check-in prior to treatment.

1. PAYMENT: Payment is expected at the time of service. If your deductible has not been met, or a percentage is your responsibility, we expect payment when services are rendered. **Even though insurance will be filed, you are responsible for any balance after insurance processes your claim.** All charges for treatment become due and payable sixty (60) days after the date of service. These periods allow sufficient time to process insurance and make payment in full of any remaining balance. There will be a $25 charge for returned checks. If not paid within 60 days, **IKP** will begin various collection activities including, but not limited by submitting the past due account to a collection agency.
2. SELF PAYMENT (PRIVATE PAY, CASH PAYMENT): If you have no insurance coverage we ask that you coordinate your care with our business office prior to your visit. We require an advance payment for professional services.
3. MANAGED CARE: All managed care (HMO, PPO, etc.) co-payment amounts are due at the time of service. You will be charged a $10.00 re-billing fee if you do not pay your copay when services are rendered. If your insurance plan requires a referral authorization from a primary care physician, please present this at your initial visit. If you request an office visit without a referral authorization your insurance plan may deem this as **"out of network"** or **"non-covered" treatment**, and you will be responsible for a larger amount or all of the charges. By signing below, patient acknowledges that it is the patient's responsibility to be aware of what services are covered, and agrees to pay for any service deemed to be non-covered or not authorized by the plan.
4. MEDICARE: IKP physicians are participating providers with the Medicare program and accept as payment: the Medicare allowable, patient deductible and/or 20% co-insurance. If you have a supplemental insurance (Medigap) to cover the portion of the charges that Medicare does not pay, please provide us with a copy of your insurance card and any forms your insurance company may require. Medicare or secondary carriers do not cover some procedures and supplies. Please make certain you understand which aspects of your treatment are covered before proceeding. You will be asked to sign a waiver form, which states that you understand that you will be responsible for these charges.
5. AUTOMOBILE ACCIDENT PATIENTS: We do treat automobile accident patients. However, we are unable to monitor long term accounts and require payment as a self-paying patient. We will not accept a letter of protection from an attorney as a guarantee of payment or third party insurance payments.
6. CHILDREN OF DIVORCED PARENTS: Responsibility for payment for the treatment of minor children whose parents are divorced rests with the parent who seeks the treatment. Any court-ordered responsibility judgment must be determined between the individuals involved, without the inclusion of **IKP**.
7. SECONDARY INSURANCE: The Texas Department of Insurance requires the patient to provide secondary insurance coverage to the provider, if applicable. Patient agrees to provide such information as outlined below. Patient agrees to notify provider in the future, immediately, of any additions, changes or deletions in primary or secondary insurance coverage. Initial/complete as applicable.
_____I have no secondary insurance coverage.
_____I have secondary insurance coverage as described on the attached Patient Demographic form.
8. RECORDING BY PATIENTS: We respect the strict confidentiality of the physician-patient relationship. We ask the same of you. By signing below, you agree that you will not make any recording of any person in this facility without their express written permission.
9. **FORMS**: If you are needing forms completed, please allow up to 5 business days for your forms to be completed. Also note that most forms are subject to a fee, ranging from $25-$65. If you have a form that needs completed, be sure to let the receptionist know when scheduling your appointment.

Please note the following charges will apply to ALL patients:
Medical Records: In accordance with the Texas Medical Board guidelines, a fee of $25.00 (non-payable by your insurance company) for the first 20 pages and $0.50 per page for every copy thereafter. In addition, fees may include the actual cost for mailing, shipping or delivery of records. Fee of $25.00 for missed appointments. A minimum of 4 hours advance notice is required for routine office visits and a 24 hour advance notice is required for Physicals and/or Well Woman Exams.

IKP firmly believes that a good patient/physician relationship is based upon understanding and open communications. It is our hope that the above policies will allow us to provide the highest quality care to our patients. If you have any questions, or need clarification regarding these policies, please call us at (281) 587-1700.

_____ _____
Patient Name (Please Print) Patient Date of Birth

_____ _____
Signature (Insured / Guardian) Date