IMB | INTERNAL MEDICINE of BRIGHTON

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INTERNAL MEDICINE OF BRIGHTON, PLLC
300 WHITE SPRUCE BLVD SUITE 100
ROCHESTER, NY 14623

FINANCIAL POLICY

Patient Name: _____
Account Number: _____

We would like you to understand the following policies regarding payment for your medical services.

1. It is your responsibility to keep the practice updated with your most current information (insurance, address, phone, etc.). If you move or if you temporarily relocate for more than one month, please notify our office.
2. Any questions regarding benefit issues or physician participation status should be directed to your insurance company.
3. We require 24 hours prior notice to cancel an appointment. If you do not provide 24 hour notice to cancel an appointment, a $25 charge may be applied to all no show office visits and a $50 charge may be applied to all no show physical appointments.
4. Returned checks will incur a $25 returned check fee. In the event of a second returned check, your privilege to pay by check in the future will be terminated and you will be expected to pay with cash or credit card.
5. You may have insurance coverage. If your insurance does not cover the contracted amount for the service provided, you will be responsible for the balance. Also, if your insurance lapses, you will be responsible for the charges in full. Please bring your insurance card every time you visit. If you do not have medical insurance, you will be expected to pay for the visit at the time of service.
6. Our doctors participate with several HMOs plans. If you are a member of an HMO, please be sure that you have the appropriate doctor listed as your Primary Care Provider (PCP). We cannot change your PCP with your insurance company. Only you can select your PCP. If the correct doctor is not listed as your PCP at the time of your visit, you may be responsible for the charges.
7. HMO insurance companies require that you pay your co-payments at the time of service. If you do not pay your co-payment at the time of service, a billing charge of $10 may added to your account.
8. We can submit claims for many insurance companies through our claims process. If you have a commercial insurance plan, we can submit claims for you upon request. Submitting claims does not mean that we are participating providers with your insurance company.
9. If you want us to submit claims to an insurance company, your signature below indicates that you understand and agree that:
    a. Information about office visits will be shared with your insurance company to facilitate payment.
    b. In most situations, your insurance company will make payment directly to this office. For those insurance companies that make payment to the patient, we will be billing the responsible party once the claim has been sent to the insurance company.
    c. You will be responsible for balances not covered by your insurance. We will bill the responsible party on your account this remaining balance. If the balance is not paid within 30 days, a $10 billing fee will be added to your account and will continue to be added with each billing cycle until the balance is paid.
10. We will keep an electronic scan of your insurance card on file.
11. Our office complies with Payment Card Industry Data Security Standards, relating to our use of your credit card information. Although we don't store your credit card information anywhere in our office or on our computer system, our credit card processor can store this information through an encrypted token for future use within our office. We require your permission to save this token.
12. It is understood and agreed that in the event any outstanding balance has to be referred to a collection agent or attorney for recovery, the patient will be fully responsible for any cost, including, but not limited to attorney's fees.

Please sign below to indicate that you have read and fully understand this policy. Thank you.

Responsible party print name: _____

Responsible party signature: _____ Date: _____