IHG Office & Financial Policies & Patient Consent Attestation Form

Inspired Health Group (IHG) is committed to providing you with care and would be happy to discuss our policy with you at any time. Your clear understanding of our Policies is important to our Professional Relationship. Please ask if you are unclear regarding our fees or policies and your financial responsibility.

Identification:

In the interest of protecting against identity theft, we require each patient to regularly present a valid current insurance card and a valid picture ID. A copy of your ID will be scanned into your medical record for this purpose. We request patients inform us immediately of change in phone number, email, home address or health insurance preferably through your Patient Portal.

Pediatric Patients:

Children under 18 years of age must be accompanied by a parent or legal guardian, or with a designated family member or friend if consent has been previously signed and in the child's chart.

Custodial Parent Responsibilities:

The custodial parent/guardian is responsible for payments at the time of service whether the child has insurance or not.

Insurance Participation and Financial Responsibility:

It is the patient's responsibility to be aware of their insurance coverage, policy provisions, authorization requirements as well as network providers, if applicable. Insurance information must be given to us at the time of service. We will bill insurance companies as a courtesy to you. If we have not received payment from an insurance company within 60 days of the date of service, you will be expected to pay the balance. We provide you with all necessary information to submit your claim to your insurance company. We will not become involved in any disputes between you and your insurance company regarding deductibles, co-payment, secondary or tertiary insurances, co-insurance, covered charges, etc. other than to supply your insurance company with necessary information. The Patient is financially responsible for all charges whether or not paid by their insurance company.

Payment Due at Time of Service:

Insurance co-payments are to be made at EACH visit. If you have a high deductible insurance policy, you are required to pay $50.00 at the time of service for each appointment, and we will bill you for the remaining balance. Failure to do so may result in an additional $5.00 surcharge until such time as the deductible has been met. Our practice accepts cash, personal check, Discover, MasterCard, American Express, and Visa. IHG offers telemedicine services, both audio-only and video. As is the case with in-office services, you will be responsible for co-pays, deductibles, and coinsurance not paid by your health plan or insurance for these services. If you are in the office for a visit, it is required to pay part of your outstanding balance if one exists.

Returned Payment Checks

Returned checks will be charged back to the patient's account. There will be an additional $30 service fee for each returned check. We reserve the right to require cash or credit card for future payment on accounts with repeated returned checks.

Private Pay

The office does offer patients with no insurance a flat fee of $100 for an office visit plus any additional charges that may be incurred during the visit. These fees are due at the time of visit without exception.

Late Payments:

If the Patient does not comply with the agreed-upon payment agreement, their account will be considered past due if no payment is received within 30 days of the first account statement. If the account is considered past due, the Patient must make a 50% payment before their next appointment. If the Patient's account balance is beyond 90 days past due, they will be considered as delinquent and their account may be forwarded to a collection agency as well as the Patient being subject to discharge from the practice unless payment arrangements are made and honored. If the Patient balance should go to collections, they will incur an added fee of a minimum of $50.00 to cover the collection company's fee.

Patient Forms:

The patient will be required to pay a $15 fee for any forms that are required to be completed (i.e., disability, FMLA, etc.).

Worker's Compensation:

We do not accept worker's compensation cases. If you are seen for an illness or injury that is worker's compensation related, you will be responsible for payment of services, as these charges cannot be billed to your insurance.

Prohibition of Recording Without Consent:

Any form of recording, including audio, video, or other formats, is prohibited during encounters with any member of this practice, unless explicit written consent is obtained from the person being recorded. Consent must be documented in writing, specifying the purpose and scope of the recording. The individual to be recorded must fully understand and agree to the recording before it takes place. Any violation of this policy may be subject to discharge from the practice.

After Hours:

We provide our own after-hours coverage. IHG providers are available on call after hours and on weekends and holidays for emergencies and urgent medical matters. By calling our office number, our answering service will contact the provider on call. Be sure to disable your call blocking. Please call the office during normal business hours for non-emergency matters.

Emergency Closing:

We notify our answering service when extreme bad weather or other emergency situations force the closure of our office. If possible, we will also notify the local media (Channels 2, 4, 7 and will post on our website at www.IHGWNY.com) if there is a weather emergency that prohibits us from having normal business hours.

Financial Responsibility:

Inspired Health Group is not liable for any purchases or orders made through our office. All sales are final, and items purchased from Inspired Health Group are non-refundable and cannot be exchanged.

Assignment of Benefits and Consent for Treatment:

I hereby assign all medical benefits to include my insurance benefits to which I am entitled, including Medicare, private insurance, and any other plan to Inspired Health Group. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize my physician to perform any medical treatment as deemed necessary.

Cancelled, Rescheduled, and No-Show Appointments:

Patients are required to notify our office at least 24 hours in advance of an appointment to cancel or reschedule, or it is considered a No-Show. If the patient is 15 minutes late or more, it may be considered a No-Show, and they may be required to reschedule and charged a No-Show fee detailed below. No-show appointments limit our ability to provide timely care to other patients and disrupt the workflow of our healthcare professionals. The patient may be reviewed for release from our practice for repeated No-Shows.

No-Show Fee Policy

Our Commitment to Your Health and Time

At our medical office, we value the health, well-being and time of our patients, as well as the time and effort of our healthcare professionals. To better ensure the highest level of service and efficiency, we have established a "No-Show Fee Policy." This policy outlines the expectations and responsibilities regarding appointment attendance and the associated fees for missed appointments.

1. Appointment Confirmation

To serve you better, we kindly request that all patients confirm their appointments by responding to the reminder messages sent by our office in the form of text, email or telephone.

2. Cancellation Policy

If you need to cancel or reschedule your appointment, please notify us at least 24 hours prior to your scheduled time. This allows us to accommodate other patients who may require medical attention.

4. No-Show Fee

In the event of a No-Show as defined above, a No-Show fee will be charged. This fee is intended to partially cover the costs associated with the missed appointment and is not covered by insurance. The no-show fee is as follows:

- Regular office visits: $50
- Extended office appointments: $100 This includes visits for:
    - New Patients
    - Hospital Follow-Ups
    - Medical Clearances
    - Medical Procedures
    - Annual Physicals
    - Annual Wellness Visits
    - Well Child Checks

5. Exceptions

We understand that emergencies and unforeseen circumstances can arise. If you are unable to attend your appointment due to an emergency, please contact our office as soon as possible to discuss a fee waiver or rescheduling options. We will extend an unforeseen circumstances courtesy of 1 no-show per year waiving the no-show fee.

6. Payment of No-Show Fees

No-show fees are expected to be paid before scheduling any future appointments. Payment can be made online through our website, via phone, or in person at the office.

7. Repeated Missed Appointments

Patients who repeatedly miss appointments without proper notice may be subject to additional actions, including the requirement to prepay for future appointments or, in extreme cases, being discharged from the practice. Any individuals that no-shows their New Patient visit twice, will not be offered an opportunity to re-schedule nor accepted into our practice.

8. Questions or Concerns

Our office is committed to clear and open communication. If you have any questions or concerns regarding our No-Show fee policy, please do not hesitate to contact our Billing and Collection Team for clarification.

Sharing Your Health Information:

We participate in CIPA Western New York IPA, Inc. dba Catholic Medical Partners (CMP) and CinqCare which are Independent Practice Associations and is the case of CinqCare; an Accountable Care Association. These are Federally and NYS regulated organizations created to coordinate your care and to reduce unnecessary or duplicate medical procedures or tests. By signing this form, you allow us to share your health information with and receive information from this organization and share with and receive such information from other health care providers who are participating in this organization, in order to coordinate your care. A list of those participating providers and further information can be found at www.catholicmedicalpartners.org. Note that the health information you are allowing us to share may include alcohol and drug treatment information, HIV/AIDS information, mental health conditions, and/or information about sexually transmitted diseases.

Thank you for your anticipated understanding and cooperation with the Office and Financial Polices above. By adhering to these policies, we can better provide the highest quality of care we aspire to, for all of our patients.

I have read, understand and agree with these Inspired Health Group Office and Financial Policies.

Signature: _____ Date: _____