

Thank you for choosing Innovative Primary Care as your health care provider. Please carefully read and initial by each statement and sign below. This policy has been put in place to ensure that financial payments due are received in a timely manner, allowing us to continue to provide quality medical care for our patients. It is important that we work together to assure that payment for services is as simple and straightforward as possible. Our billing department will be glad to discuss these policies with you.

1. _____ I understand that if I do not have my insurance card and/or co-payments the day of the appointment, that my appointment may be rescheduled until such time that I can provide documents or payments.
2. _____ I understand that Innovative Primary Care will collect deductibles and coinsurance up to an amount equal to payment in full for the planned office visit, prior to any office visit and procedure takes place. Payment in full and expected coinsurance payment responsibility are determined by the anticipated medical billing codes(s), details of your insurance policy, and agreement between your insurance company and Innovative Primary Care.
3. _____ I understand that if my account is not paid in full within 90 days, a 30% collection processing fee will be added to the outstanding balance and will be turned over to collections for further processing. No additional appointments will be made for delinquent accounts until they are brought current. You will be required to pay cash for all future office visits prior to being seen.
4. _____ I understand that a \$35 service fee will be added for any checks returned for any reason and I will be responsible for payment of this fee and the amount of the returned check. NSF checks must be redeemed with certified funds (cashier's check, money order or cash).
5. _____ I understand that if I am unable to attend a scheduled appointment I need to contact the office at least 24 hours before my scheduled appointment time. Due to a high demand for appointments, missed appointments prevent us from scheduling appropriately and keep others in need of care from being seen. I also understand that if I am late for my appointment that I may not be seen that day and will need to reschedule. A \$55 fee will be assessed for all missed appointments not cancelled with a 24 hour advance notice. For any physical exam appointments not cancelled 24 hours in advance, a \$75 fee will be assessed.
6. _____ Innovative Primary Care will allow 60 days from the date of filing for my insurance company to process or pay a claim. Arizona law allows insurance companies operating in the state no more than 30 days to process claims. It is my responsibility to provide my insurance company with requested information needed to process a claim for services. It is also my responsibility to notify Innovative Primary Care if there is any change in my insurance coverage, residence or phone number. Ultimately, it is up to me to know my insurance benefits.
7. _____ If I choose to see a Naturopath MD (NMD), I will be responsible for payment of \$145.00 for a new visit and between \$80.00-\$120.00 for all follow up visits.
8. _____ I have received a copy of the Notice of Privacy Practices.
9. _____ I have read and understand the above Financial Policy and I agree to abide to its terms.

Patient or Guardian Signature: _____

Patient or Guardian Name (Print): _____

Date: _____

Effective 11/15