Internal Medicine Associates of Plano and Frisco, PA (IMAPF)
Internal Medicine Associates of Plano, PA (IMAP)

Patient Information:

Name: _____ DOB: _____Age:_____
Address:_____City:_____State:_____Zip:_____
SSN#: _____Sex: _____ Marital Status: _____ e mail:_____
Alternate e mail:_____ Home #:_____ Cell #: _____
Work #: _____ Fax # (only if secure):_____ Occupation:_____
Did someone refer you to us: _____

Emergency Contact Information:

Spouse: _____ Phone #'s _____
Relative: _____ Phone #'s _____
Friend: _____ Phone #'s _____

Primary insurance:

Name of Insurance:_____ Type (HMO/PPO/POS/ect…)_____
Insurance Address:_____
Group #:_____ Effective date:_____
Insured SS#:_____ Insured DOB:_____
Insured Employer:_____ How long at the current employer: _____

Secondary insurance (if applicable):

Name of Insurance:_____ Type (HMO/PPO/POS/ect…)_____
Insurance Address:_____
Group #:_____ Effective date:_____
Insured SS#:_____ Insured DOB:_____
Insured Employer:_____ How long at the current employer: _____

Patient/Responsible Party Authorization:

I authorize the release of medical information as decided by providers of IMAP/IMAPF and staff to process my claims. I request that payment of medical benefits be made to IMAP/IMAPF. This assignment of benefits will remain in effect until revoked by me in writing.

_____ _____
Patient's Name Date

Manner of Contact:

By my signature below I authorize the staff at IMAP/IMAPF, to contact me by e mail or through any of the phone numbers listed above and to leave message as they deem necessary regarding my health and test results. I realize that e mail is not secure. This authorization will remain in effect until revoked by me in writing.

_____ _____
Patient's Name Date

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PAYMENT POLICY

We will file insurance for our PPO, HMO, and other managed care patients. However, all managed care co-payment and/or deductible and coinsurance amounts are due at the time of the service. Any disallowed/uncovered amounts are due from the patient. It is your responsibility to make sure that the providers whom you see are in your managed care network.

Patients who do not cancel or reschedule their appointment at least 24 business hours prior to their scheduled visit will be charged a fee of $50.00. This fee also applies to any patients that do not show up for their scheduled appointment. Excessive no shows and/or late cancellations could be grounds for termination from Internal Medicine Associates of Plano.

We accept assignments and will file insurance for our Medicare patients. However, any calendar year deductible amounts (to the extent of the visit amount) are due at the time of service. We will only file secondary claims when Medicare is the primary insurance. If there is no secondary insurance, then we will bill the patient for any remaining balance unpaid by Medicare.

There will be a twenty-five ($50.00) fee charged for any returned check. This fee is charged even if the check is re-deposited because the bank has already charged us a fee for the returned item. You will subsequently receive a bill for this amount. Payments will be expected in the forms of cash, money order, Visa, MasterCard, American Express, or Discover. If payment is not received by the due date indicated on the bill, then your information will be turned over to the Collin County District Attorney. After receiving a returned check we will no longer accept checks as a form of payment on your visits for up to five years.

Your insurance policy is a contract between you and your insurance company. It is important that you understand its provisions. We cannot guarantee payment of your claims. Reduction or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred. We will attempt to verify coverage, although this is not a guarantee of payment until your insurance has processed the claim.

For all account balances more than 90 days past due, a late fee of $50.00 will be added to the balance (even if the payment delay is due to the insurance company). The account will be turned over to our collection agency if payment is not received 15 days after notification. It is ultimately the patient's responsibility to make sure that Internal Medicine Associates of Plano receive payment for services rendered.

We will file insurance for our HMO, EPO, POS, and Open Access patients. However, you must have assigned the physician you are seeing in this office to be your Primary Care Provider (PCP) ***prior*** to your first office visit/appointment. The assignment of the PCP must be effective the day services were rendered (or beforehand). If you have not assigned the provider you see in our office as your PCP, you agree to be responsible to pay the entire balance for your visit. If you would like to meet with the physician prior to choosing him or her as your PCP, you will have to assume full responsibility for the amount of that visit as your insurance will not cover the visit until PCP status has been assigned by you.

I have read this agreement and understand the provisions outlined. I agree to be responsible for any balance present on my account. If my insurance denies payment because the provider I saw was not assigned as my provider at the time of service, I will assume full responsibility of the charges incurred for that visit and will pay in full.

If any patient is owed a refund, all claims must be processed and paid in full before an overpayment is refunded. IMAP/IMAPF processes refunds 1 time a month, typically on the 15th of the month. All refund amounts less than $100.00 will be left as a credit on your account, unless a refund is requested by you.

PRECERTIFICATIONS/REFERRAL AUTHORIZATION

Referrals: Due to the tremendous number of referral requests, we must be notified at least five (5) business days prior to your appointment with the specialist in order to provide the formal referral necessary for that provider. Patients who see specialty care providers first and then call after the fact to request a referral number run the risk of reduction of benefits as most insurance companies do not back date referrals. We will not be responsible for any reduction of benefits due to "after- the- fact" referral request. When referred, it is the patient's responsibility to verify that the physician or facility is in their insurance network.

AUDIO/VIDEO SURVEILLANCE OF THE BUSINESS/PUBLIC AREAS OF THE OFFICE

I have been informed and understand that the office utilizes audio and video surveillance of the business/public areas in an effort to serve me better and for the protection and safety of all the patients and staff. There is NO recording or surveillance in the exam rooms and restrooms!

BASIC RULES

I further understand that antibiotics and pain medicine will not be prescribed without a visit. The patient portal is not checked daily, and it is not for emergency use. If you have any issue you need to schedule a visit to see us.

You authorize us to send you text messages and to call any individual or phone number that you provide on your patient profile and to leave a message if needed.

TELEVISTS

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
    a. I may revoke my right at any time by contacting IMAP/IMAPF
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
    a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
    b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.
    c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.

AUTHORIZATION

I authorize the release of medical records to determine liability for payments or treatment, and to obtain reimbursement.

I assign all medical benefits for office visits and procedures to the providers at IMAP/IMAPF. This assignment will remain in effect until revoked by me in writing. A photocopy of this document will have the same validity as the original.

Patient Name (please print) _____

Patient/Parent or Guardian Signature _____ Date _____