Policy Statements

No Show / Cancellation Policy:

Our goal is to accommodate all of our patients' health care needs and schedules to the best of our ability. Therefore, we ask for a 24-hour notice if you are cancelling an appointment. This allows us to ensure all available appointment time can be utilized for patient care. If you fail to notify us of a cancellation you will receive a written warning. This will include a signed statement that you have reviewed and understand our cancellation policy. For a second offense, you will be charged a $25 cancellation fee. If three appointments are missed with improper notice you may be dismissed from the practice.

Late Policy:

If you are more than ten minutes late for a "well care visit or physical" you will be considered a "No Show" and may be asked to reschedule your appointment. In addition our No-Show policy will be instituted. If you are more than 5 minutes late for a "sick" visit, we will make our best effort to see you in a timely fashion: however, patients who are on time for their appointments will be given priority and late patients will be seen only if time permits. You may also request to reschedule for an appointment time later in the day, and we will do our best to accommodate your needs.

Financial Policy:

IPHC will assist you with filing insurance claims to help you receive the maximum benefits allowed. Therefore, at the time of service, it is your responsibility to provide us with complete and accurate insurance information. A current insurance card must be provided for verification. If you do not have medical insurance, our staff will provide you with information regarding payment options.

Payment for health care services may be your responsibility if your insurance company does not pay or does not cover the services provided for you or your child. Please determine the extent of coverage and potential for personal liability before we provide services to you. We are happy to provide an estimate of cost upon request. All patients or legal guardians must complete and sign the Consent Form before being seen by a provider.

Co-payments must be made upon check-in. We accept cash, checks, Visa, MasterCard and Discover. No post-dated checks will be accepted. For all returned checks there will be a $40.00 return check fee. Co-payments cannot be waived, there will be a $15 charge for non-payment of co-pays at the time of service.

We allow 60 days from the date of service for the insurance company to pay their portion of the office bill and the next 60 days for you to pay your portion. For patient account balances that are greater than 120 days, an interest charge will be applied at a rate of 18% per annum. In addition, the account will be placed on a payment plan with a minimum payment due of $50 per month for accounts with balances of $500 or greater. The responsible party will have the option of providing a valid credit card for automatic processing of payments. Payment plans are available for all account balances.

Accounts will be turned over for collection if no payment is made after 120 days. If your account is placed for collection with an agency for non-payment, the undersigned Responsible Party agrees to pay

all costs of collections including, but not limited to, court costs, reasonable costs of collection charged by the agency, and reasonable attorney fees, as permitted by statue or court judgement.

Electronic Medical Records:

IPHC supports the secure electronic exchange of health information as a means to improve the quality of your health care experience. We participate in Colorado Regional Health Information Organization (CORHIO), Colorado Immunization Information System (CIIS), as well as insurance, pharmacy and lab clearinghouses. Using Health Information Exchange (HIE) networks helps us to more effectively and efficiently share information about your medical care with other providers that participate in the network. The HIE enables emergency personnel and others to have access to your medical data that may be critical for your care. Making your health information available to other health care providers can potentially reduce your cost by eliminating unnecessary duplication of test and procedures.

You may, however, choose to opt-out of participation in the HIE, or cancel an opt-out choice at any time. Please speak with one of our staff members if you choose to opt-out.

Consents: I hereby consent to the treatment of the child/ren listed below as the parent or legal guardian of the child/ren. I have read and understand the above policies and agree to abide by the terms. I consent to the use or disclosure or protected health information for purposes of diagnosing, or providing treatment, or obtaining payment for health care bills or to conduct health care operations for the child/ren listed below. I understand I have the right to review the Notice of Privacy Practices prior to signing this document.

_____ _____

Printed name of Responsible party Date Signed

_____

Signature of Responsible Party

Office use only:

Patient ID's associated with this consent:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Effective April 1, 2016