

**INSTITUTE FOR SPECIALIZED MEDICINE**  
12865 Pointe Del Mar Way, Suite 130  
Del Mar, CA 92014

phone (858) 794-9192  
fax: (858) 794-9164  
e-mail: [info@ifsmed.com](mailto:info@ifsmed.com)

## **FINANCIAL POLICY STATEMENT**

Welcome to the Institute for Specialized Medicine (IFS MED). We are pleased to have you as a patient and we are committed to providing you with the best medical care possible. In order to assist you in receiving the maximum benefits allowable by your insurance, we ask that you read and sign this statement. The following is a statement of our Payment Policy, which we ask you to read and sign prior to any treatment.

**Payment, according to the policies below, is due at the time of service.**

### **Forms**

All patients must complete the Patient Registration form and provide complete insurance information **before** seeing the doctor. We can bill your insurance plan(s) only if you give us complete information, and a signed, dated claim form (if required by your plan).

**If you cannot supply us with sufficient insurance information, we will consider the entire bill to be the patient's responsibility, and full payment will be due at the time of service (see Patients Without Insurance section below).**

### **Patients with Insurance**

**All co-payments, deductibles, coinsurance, and charges for non-covered services are due at the time of service.**

You will be required to sign an Authorization to Pay Benefits form, allowing payment to be made directly to our office, and we will file insurance claims on your behalf. If your insurance plan has not paid your account in full within **60 days**, the balance will become your responsibility, as your insurance policy is a contract between you/your employer and the insurance company. We are not a party to that contract. Please be aware that some and perhaps all of the services provided may be considered non-covered or not reasonable and customary charges under your medical plan, and may become your responsibility. Please read carefully your Evidence of Coverage booklet that you receive from your insurance company, as to what types of services are not covered under your policy.

If you have an HMO policy that requires the use of referrals for out-of-network providers, you must present to the office with referral in hand. It is the patient's responsibility to obtain a referral from your primary care physician. If you have an HMO plan and choose to be seen with out a referral, a waiver will be signed and deposit payment of \$100.00, will be due before seeing the physician. If there is a remaining balance for the services rendered, those fees will be due at the end of the visit.

If you prefer, you may notify our staff that you prefer to file your own insurance claim, in which case we will require **full payment of all charges at the time of service** and will provide you with an itemized receipt to submit to your insurance plan.

### **MEDICARE PART B**

IFS MED participates with Medicare and accepts assignment. We will file your claim and require that you pay any deductible and your 20% co-insurance at the time of checkout. In order to receive a non-covered supply or service, you will be required to sign a Medicare waiver and pay in full. If you have a secondary insurance, we will file for you, and you will be billed for any remaining balance. IFS MED does not participate with any Medicare Advantage Plans. If you have a Medicare Advantage HMO plan, you will not have any out of network benefits. If you are covered by a Medicare Advantage PPO plan that allows you to go out of network, you may have deductible and co-insurance payments that are determined by each individual Medicare Advantage Plan.

**Patients without Insurance**

Payment in full is due at the time of each service. If you are unable to pay the entire balance at the time of service, you will be required to pay a \$100 deposit and sign a Promissory Note making arrangements for a payment plan. The \$100.00 deposit does not cover the office visit for that day; it only covers a portion of the charges.

**Work-related/ Auto Accident Injuries**

We do not file Workers Compensation/PIP claims on your behalf. If you choose us to take care of your work- or accident-related injuries, you will be subject to the same payment policy as patients without insurance (see above paragraph).

**Minor Patients (dependent children under age 18)**

The adult accompanying a minor and or the parents (or guardians) of the minor are responsible for payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit card or payment plan, or payment at the time of service has been verified.

**Missed Appointments**

Unless canceled at least 24 hours in advance, we will charge your account \$25.00 for each missed appointment. If you are a new patient and you miss your initial visit the fee will be \$50.00. Please help us serve you and all of our patients better by keeping scheduled appointments.

**Interest**

We reserve the right to charge interest on patient balances unpaid after 30 days at the rate currently allowed under California Law.

**Default**

Regardless of insurance coverage, if after default, your account is placed in the hands of an attorney or collection agency for collection, the undersigned agrees to pay a service charge of 25% of the unpaid balance and all attorney and/or collection fees, together with all additional costs and expenses of collection to the present extent of the law.

**Returned Check Fees**

If your check is returned to our office due to insufficient funds, a fee of \$30.00 will be assessed as well as a \$25.00 servicing fee, plus the amount of the check. Payment will then need to be made in the form of cash, credit card, or money order for all future visits. Thank you for taking the time to read and understand our Payment Policy. Please let us know if you have any questions before signing below. Your signature indicates that you have read this policy and understand and agree to its terms.

**ASSISTANCE**

Our office manager is available to assist you with any special concerns or questions. Please feel free to call (858) 481-6126 or e-mail us at [info@ifsmed.com](mailto:info@ifsmed.com).

I hereby state that I have read, understand, and agree to the terms on this policy.

X \_\_\_\_\_  
Signature of patient or responsible party

Date \_\_\_\_\_

*Thank you for choosing the Institute for Specialized Medicine a state-of-the art medical facility for comprehensive care of arthritis and rheumatism.*