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## 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 Financial Policy Statement, 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, the Patient History form, sign the HIPPA Acknowledgement form and provide complete insurance information **prior** to the execution or delivery of any service/supply. 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 services/ supplies that are non-covered or not medically necessary including those deemed as experimental and investigational are due at the time 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/or perhaps all of the services/supplies provided may be considered non-covered, not medically necessary, experimental and investigational, not reasonable and customary under your medical plan and may become your responsibility. Please carefully read your Evidence of Coverage booklet that you receive from your insurance company. This booklet will provide you with documentation as to what types of services/supplies are non-covered, deemed not medically necessary, considered experimental and investigational, not reasonable and/or customary under your policy.

If you have an HMO policy that requires the use of referrals for out-of-network providers, the referral either needs to be provided prior to the date of service or brought in by hand the day of your scheduled appointment. Please be advised 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 without a referral, a waiver will be signed and a 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 **payment in full of all charges due at the time of service** and will provide you with an itemized receipt to submit with 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, not medically necessary, experimental and investigational, not reasonable and customary supply or service, you will be required to sign a Medicare waiver and pay in full. If you have a secondary insurance, we will add it to your file 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

If you do not have insurance payment in full is due at the time of each service **before** services are rendered.

*Thank you for choosing the Institute for Specialized Medicine a state-of-the art integrative care for Arthritis and Autoimmune diseases.*

**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 (CHILDREN UNDER 18 YEARS OF AGE)**

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 rendered.

**MISSED APPOINTMENTS**

Unless cancelled 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.

**MEDICAL DOCUMENTATION AND/OR PAPERWORK**

We will accommodate our patients and fill out any medical documentation and/or paperwork in regards to your medical history, diagnosis(s), treatment, etc. There will be a fee for this service ranging from \$25-\$50 depending on the length of time spent to accurately fill out requested paperwork/documentation. This fee will need to be paid for prior to the release of completed paperwork.

**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 Financial 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) 794-9192 or e-mail us at [info@ifsmmed.com](mailto:info@ifsmmed.com).

I hereby agree that I understand and acknowledge my patient responsibilities written under this policy and by signing below I am bound to agree and comply with all terms stated above.

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

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