Welcome to IMUA Orthopedics, Sports & Health! We are glad that you have chosen us to take care of your health care needs, and we look forward to partnering with you to realize your health care goals. In order to keep you informed of our Office and Financial Policies, we ask that you read and sign our acknowledgement prior to any treatment. Please speak with us if you have any questions.

OFFICE POLICIES

APPOINTMENTS – The office hours for each physician will vary, but every effort will be made to accommodate the date and time desired. Office visits are by appointment only. While every effort will be made to keep your wait time to a minimum, emergencies do occur and will be given priority. We will attempt to contact you as soon as possible to provide the option of rescheduling your appointment

CANCELLED APPOINTMENTS / NO SHOWS - If it is necessary to cancel your appointment, we kindly ask that you give us at least 24 hours notice so that we may accommodate other patients in need of our services. Please note that a $30.00 Cancellation/No Show fee may be billed to you (which is not payable by your insurance) for any missed appointments if proper notification has not been received by our office. Repeated "No Shows" may result in a temporary suspension of services.

AFTER HOURS EMERGENCIES – If you are having a medical emergency, please call 911 immediately and go to your nearest emergency room. Our physicians can also be reached after hours through the Physicians Exchange at 524-2575.

PRESCRIPTION REFILLS – Please call our office during normal business hours to obtain medication refills. This will allow your physician to consult your medical record and make the best decision regarding your care. Prescriptions will be called in within 48 hours of request. Refills will not be handled after hours, and will be only considered under emergency circumstances.

MEDICAL FORMS COMPLETION - A $10.00 - $25.00 fee will be charged for completion of insurance forms such as TDI, Life Insurance, or Flexible Spending forms (the charge is based upon the number of pages and complexity of the information requested). Payment is required at the time the forms are picked up.

REQUEST FOR COPIES OF MEDICAL RECORDS - If you are requesting a copy of your medical records for yourself or a third party, we require a signed authorization by the patient or their Legal Representative. This form may be faxed in to 521-8127. Please allow ten (10) days' notice. There may be a fee charged for this, and payment in full is required before the records can be released.

FINANCIAL POLICIES

IMUA Orthopedics, Sports & Health participates with most insurance plans. We will gladly file claims on your behalf, however, payment for any services that we provide will ultimately be your responsibility if not paid promptly by another party. You will be required to complete an Injury/Illness form stating that your injury is NOT the result of a third party's liability.

HMO / MANAGED CARE PLAN REFERRALS - Some insurance plans require that you obtain a referral from your primary care provider in order for your visit to be covered. Failure to obtain the necessary referrals may lead to your visit being denied, and as a result, your having to be responsible for the entire balance. If you arrive for your appointment without a referral, we reserve the right to reschedule your appointment.

WORKERS' COMPENSATION / AUTOMOBILE ACCIDENT / THIRD PARTY LIABILITY – If your injury is a result of a work-related injury, automobile accident, or due to another party's negligence, we must have approval from your adjuster prior to your visit. Failure to properly report the injury to your employer/insurance carrier may result in your claim being denied and the balance being your responsibility.

PAYMENT AT TIME OF SERVICE - We ask that you remit payment for any applicable co-payments, deductibles, or co-insurance amounts at the time of service. Once your insurance carrier has processed your claim, any outstanding balance not collected at the time of service will be billed to you.

If you do not have any insurance coverage, we do not participate with your insurance carrier, or if there is a question of whether or not your insurance carrier will cover your visit, we require payment in full at the time of service. In the event that your insurance carrier does make payment, you will be refunded your payment less any balance due.

If you do have an outstanding balance due, we would appreciate your prompt payment in full. In the event that you are unable to make payment in full, please call our business office at 521-8170 and we will be happy to arrange a payment plan for you.

DELINQUENT ACCOUNTS - If multiple attempts to collect payment from you are unsuccessful, we reserve the right to turn your balance over to a collection agency. In addition to the balance due, you will also be responsible for any legal or collection agency fees due.

RETURNED CHECKS – A $20.00 fee will be assessed for each check returned for insufficient funds.

ACKNOWLEDGEMENTS AND CONSENTS

Patient Financial Responsibility:

I acknowledge full financial responsibility for services rendered by IMUA Orthopedics, Sports & Health, LLC as detailed above.

Consent for Purposes of Treatment, Payment, and Healthcare Operations:

I hereby give my consent to IMUA Orthopedics, Sports & Health to use or disclose, for purposes of carrying out treatment, payment, or healthcare operations, all protected health information contained in the health record of: ________________________________ *(print patient's name)*. I understand that this facility may share my information electronically or on paper with other providers in the course of my treatment, for making arrangements for my continuing care, or upon request when seeking care from other providers. If I prefer that this medical facility not use or share my information, I may submit a written request for consideration per this facility's Notice of Privacy Practices.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to disclose my health information. Written revocation of consent must be sent to this facility.

Acknowledgement of Receipt of Notice of Privacy Practices:

I acknowledge that I was made aware of IMUA Orthopedics, Sports & Health's Privacy Policy and a copy was available for my review.

My signature below indicates my full understanding and consent to the above-described policies.

____ ____ Date: ______________________________

Signature

____ ______________________________

Print Name Relationship to Patient