Internal Medicine Associates
8895 Broadway • Merrillville, Indiana 46410 • (219) 738-2081 Fax (219) 736-4658

Acknowledgement of Financial Policies

1) I understand that I am responsible for the payment in full of all services rendered by Internal Medicine Associates (IMA), subject to any limitations set forth in any applicable insurance or other third-party benefits contract.

2) I agree that I will pay all applicable insurance or other third-party benefits copayments, deductibles, and outstanding balances for which I am responsible at the time of service.

3) I understand that the billing department of IMA will file all applicable claims for services rendered to my insurance or other third-party benefits carrier. I agree to provide IMA at the time of service with information required by IMA to bill my insurance or other third-party benefits carrier including my name, address, insurance or other third-party benefits card, and driver's license. I agree to notify IMA at every visit of any change in my employment, insurance or other third-party benefits address or phone number. After the service is rendered I agree to work with the IMA billing department and my insurance or other third-party benefits carrier to timely provide any information needed by IMA or my insurance or other third-party benefits carrier to process my claim.

4) I understand that I am responsible for any services which my insurance or other third-party benefits plan determines are not covered by the plan, out-of-network fees, and for any other amounts which are due and are not required to be written off by the contract (if any) IMA has with my insurance or other third-party benefits carrier. I agree to pay any such amount in full to IMA within 30 days of being notified by IMA of the balance due.

5) If I am unable to pay the amount in full within 30 days, I agree to immediately contact the IMA billing department at (855) 301-5672 to determine if I qualify for a monthly payment plan.

6) I understand that failure to pay my balance or arrange for regular payments and follow that payment agreement may result in my account being turned to a collection agency. I agree that I will be responsible to pay for all collection fees in the event my account balance is turned to a collection agency after 90 days due to nonpayment.

7) In the event that I pay by check and the check is returned due to non-sufficient funds, I agree to pay IMA a processing fee of $25.00 in addition to any account balance I have for services rendered.

8) If I do not have any health insurance, I may contact the IMA billing department at (855) 301-5672 to determine if I qualify for one of the below:
   a. Financial hardship discount. Contact the IMA billing department to obtain the information required to determine qualification for a financial hardship discount.
   b. Discount based upon the procedure/service and advance payment for patients without insurance. Contact the IMA billing department for details.

I certify that I understand and agree to comply with the financial responsibilities listed on this form. I further certify that I have received a copy of the Internal Medicine Associates, LLC Patient Payment Policy.

_____
Printed Name of Patient or Responsible Party

_____ _____ _____
Signature of Patient or Responsible Party Date Relationship to Patient