

Financial Policy

Full payment is expected when you check out for any co-pays, co-insurance or non-covered services. We accept Cash, Checks, Visa, MasterCard, Discover and American Express. If there is a problem regarding payment, ask to speak to the billing manager BEFORE you see the doctor. We can attempt to estimate the charges which you are likely to incur.

Patient's Home #:	Patient's Work #:	Extension	Patient's Cell #:	Patient's Pager #:
Patient Name:				Date of Birth:
Address:			Apt #:	City, State:
Patient's SS#:		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Marital Status(circle one): S M D W
Person Responsible For Your Account: (Full Name Please)		Relationship (Circle One) Mother Father Spouse		Person Responsible Home #: / Person Responsible Work #: /
Patient's Employer:		Employer's Address, City, State, Zip		

Please note the following charges will apply to all patient's: Fee of \$25.00 will be charged on all returned checks.
 Fee of \$25.00 (non-payable by your insurance company) to copy and forward medical records.
 Fee of \$15.00 for a duplicate referrals.
 Fee of \$5.00 for a duplicate receipt.
 Additional charges will vary on: insurance, disability or life insurance forms etc.

WORKER'S COMPENSATION: Please notify the receptionist immediately! We must verify your work related injury and coverage BEFORE you are seen. If we are unable to obtain verification, then you will be required to pay for the services and submit your bill to your employer or insurance company.

Policy Holder Information

Primary Insurance Coverage:			PCP:
Policy Holder-Full Name			Policy Holders Date of Birth:
Policy Holder's SS #:	Relationship to Patient:		Effective Date:
Policy Holder's Employer	Address, City, State, Zip		Office#:
Member ID #:	Group #:	Insurance Phone #:	
Primary Insurance Company:	Claims Address:		

Secondary Insurance Coverage:			PCP:
Policy Holder-Full Name			Policy Holders Date of Birth:
Policy Holder's SS #:	Relationship to Patient:		Effective Date:
Policy Holder's Employer	Address, City, State, Zip		Office#:
Member ID #:	Group #:	Insurance Phone #:	
Secondary Insurance Company:	Claims Address:		

Emergency Contact

Contact In Case of Emergency (First/Last Name Please):	Phone #:
Who Is Your Primary Care Physician (First/Last Name Please):	

I give my permission for the doctor's at IKP Family Medicine, P.A. to treat me/my child (circle one) as appropriate in their best medical judgment. I have read, understood and will comply with the above financial policy.

Patient/Legal Guardian Signature _____ Date _____