Patient Name: _____
Patient MRN: _____
DOB: ____/ ____/ ____
Provider: _____
DOS: ____/ ____/ ____

iHealth
Infinite Health Collaborative

i-Health Financial Policy

The following information is provided to you in order to provide a clear understanding of Infinite Health Collaborative's ("i-Health") financial policy. If you have any questions about this policy or your financial responsibilities, please call our Business Office at 952-512-5625.

Co-Payments: All co-payments are due at the time of service. We accept cash, check or credit cards. We accept the following credit cards – VISA, MasterCard, Discover, American Express and Care Credit.

Referrals and Pre-Certifications: Referrals to see i-Health providers are the patient's responsibility. If a patient does not obtain the appropriate referrals and his/her claims are denied, payment will become the patient's responsibility. If a prior authorization/pre-certification is needed; i-Health will initiate and complete the necessary information to obtain approval for your procedure and/or service. It is your responsibility to ensure the appropriate authorizations are completed prior to the service and/or procedure being rendered.

Good Faith Estimates: i-Health will provide an estimate of cost for future services. Although we will estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits including co-payments, co-insurance and/or deductible amounts.

Insurance Claims and Benefits: Your insurance policy is a contract between you and your insurance company. It is your responsibility to understand your benefits including information pertaining to co-payments, co-insurance and deductibles. As a courtesy, i-Health will file claims for benefits with all insurance companies with claims offices within the United States or its territories. In order to properly bill your insurance company, it is important that you provide all insurance information including primary, secondary and tertiary insurance, as well as, notify i-Health of any changes to your insurance information. Failure to provide this information may result in larger or inaccurate amounts of patient responsibility.

If your insurance company is not contracted with i-Health, you are considered out-of-network. If you decide to obtain care with an out-of-network provider, you will be responsible to pay any portion of the charges not covered by your insurance, including those charges above the usual and customary allowance.

Uninsured: If you are uninsured, a down-payment may be required prior to your service. Down-payment amounts will vary based on the service. If you cannot afford the down-payment, i-Health offers a Financial Assistance Program. Any remaining amounts will be balanced billed to the patient. If the patient does not bring in required payment at the time of service, the patient may be rescheduled to another day when payment can be made. A prompt pay discount of 20% will be offered for payment in full.

Financial Hardship Program: i-Health offers a financial hardship program. Please contact the i-Health Customer Service Department (952-512-5625) to review this program.

Finance Charges: Finance charges may be imposed on accounts beginning 60 days from the date of the initial billing statement. At present the interest rate is 6% per year.

Outstanding Balances: Any outstanding balances should be paid at the time of service unless prior arrangements have been made. If your insurance does not pay the balance in full, you will receive a statement. Payment is due upon receipt of your statement. Failure to pay your balance may result in your account being transferred to an outside collection agency. If your account is turned over to an outside collection agency, all balances must be paid in full prior to initiating additional treatment for a new problem. If your account is placed with a collection agency, you may be dismissed as a patient from i-Health.

Credit Balances: i-Health will refund any amounts owed to patients within 45 days of discovery, request or notification. All refunds will be processed in the form the payment was made.

***Please initial here to acknowledge receipt of the above i-Health Financial Policy: _____**

Patient Name: _____
Patient MRN: _____
DOB: ____/ ____/ ____
Provider: _____
DOS: ____/ ____/ ____

iHealth
Infinite Health Collaborative

Consent Statements

Consent for Treatment: I consent to and authorize i-Health to examine and treat me or the patient as deemed appropriate. I understand treatment could include ancillary tests, education, photographs or other diagnostic procedures. I understand that my provider is available to explain the purpose of the procedure and treatments, and that I have the right to refuse. I authorize i-Health to access patient's medical/prescription history from non-i-Health sources.

Release of Information: I consent to i-Health's use and disclosure of my health and other information outside of i-Health for treatment, coordination and care management, and healthcare operations purposes. Healthcare operations includes, but is not limited to, quality improvement activities, performance evaluations, business management and Accountable Care Organization activities. I agree that this consent will remain in effect until revoked by me in writing.

Assignment of Benefits: I request that payment of insurance benefits, including Government programs, be made directly to i-Health on my behalf for all services.

Notice of Privacy Practices: I acknowledge that I have received a copy and/or been made aware of i-Health Privacy Practices that are posted on our web-site and in the clinic reception area.

***Please initial here to acknowledge these consent statements: _____**

Research

Research: State law requires i-Health to inform you that your medical record may be released for research purposes unless you deny this release. The researchers cannot use patient identifying characteristics when reporting any results of their research. Please indicate below if you accept this request.

Accept: _____ Deny: _____

Release of Information

I authorize i-Health to verbally communicate with a designated individual regarding my care.

I authorize: _____ I decline: _____

If authorized,

1. **Please provide the first & last name of the individual: _____**
2. **What is your relationship to this individual?: _____**
3. **What is the best phone number to reach this individual?: (_____) - _____ - _____**

Patient Name: _____
Patient MRN: _____
DOB: ____/ ____/ ____
Provider: _____
DOS: ____/ ____/ ____

iHealth
Infinite Health Collaborative

Disclosure of Presence

I understand that during my visit, my friends, family, employers or others may call to inquire about my presence at an i-Health facility. I authorize i-Health to disclose information about my presence at this facility.

I authorize: _____ I decline: _____

If authorized, please provide the name(s) of the individual(s): _____
_____
_____

Authorization to Communicate Information to Voicemail

To facilitate the communication of test results and other information, I authorize i-Health to leave confidential information on my voicemail if the providers and staff are unable to reach me directly.

I authorize: _____ I decline: _____

If authorized, what phone number you would like us to use?: (_____) - _____ - _____