IHP

Innovative Healthcare Physicians

Your OBGYN Healthcare Partner

Registration

Please fax to 212 393 9405

Date: _____

Demographics					
Last name:		First name:			
Social Security Numbers:		Date of Birth:		Gender: □ M	□ F
Address:			Apt:		
Zip	State	City			
W Phone #	H Phone #	Mobile #			
Emergency Contact Name	Emergency Contact Phone#	Email (Patient)			
Ethinicity: □ Ash. Jewish □Blk/Afr. American □Not Hisp.or Latino □ Asian □ Other					
Marital Status	□ Single	□ Married	□ Divorced	□ Separated	□ Widowed

Referral Source						
Employer □	Flyer □	News Paper Ad □	Friend □	Web Search □	Physician □	Other □

Insurance				
Primary insurance company name:	Policy #	Group #		
Claims address:				
Zip	State	City		
Name of the policy holder:		DOB:		
Relation to patient:	□ Self	□ Spouse	□ Child	□ Other

Patient employer		
Name:	Phone #	
Address		
Zip	State	City

Authorizations

I authorize the release of medical information appertaining to my history, service rendered or treatment given to me or my dependents for purposes of review of this claim.

I hereby authorize payment of benefits to be made to the physician rendering the service. I will be held responsible for any costs which are not covered by my insurance carrier, and will be directly billed for such cost.

I acknowledge that I have received a copy of HIPAA Notice of Privacy Practice

Signature: Date:

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OFFICE FINANCIAL POLICY

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

1. On arrival, please sign in at the front desk and present your current insurance card at every visit. You will be asked to sign and date the file copy of the card. This is your verification of the correct insurance and consent to bill them (on your child's behalf). IF THE INSURANCE COMPANY THAT YOU DESIGNATE IS INCORRECT, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THE VISIT AND TO SUBMIT THE CHARGES TO THE CORRECT PLAN.
2. If we are your primary care physician, make sure our name or phone number appears on your card. If your insurance company has not been informed that we are your primary care physicians as of this date, you may be financially responsible for the visit.
3. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.
4. We do not submit to secondary insurance plans. If you have secondary insurance, we will provide you with a receipt to submit for reimbursement. Your secondary insurance will send the reimbursement check directly to you. YOU ARE RESPONSIBLE FOR ANY BALANCE ON YOUR ACCOUNT.
5. It is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see specialists, if preauthorization is required prior to a procedure, and what services are covered.
6. If our physicians do not participate in your insurance plan, payment in full is expected from you at the time of your office visit. For scheduled appointments, prior balances must be paid prior to the visit.
7. If you have no insurance, payment for an office visit is to be paid at the time of the visit.
8. Co-payments are due at time of service.
9. Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due *within* 10 business days of your receipt of your bill.
10. If previous arrangements have not been made with our finance office, any account balance outstanding greater than 28 days will be charged a $25 re-bill fee. Any balance over 60 days will be forwarded to a collection agency.
11. If you participate with a high-deductible health plan, we require a copy of the health savings account debit/credit card or a personal credit card remains on file. There are addenda to this financial policy, which are signed separately. IHP reserves the right to obtain a valid credit card on file for patients who has demonstrated poor credit history.
12. We require 24-hour notice for canceling any appointments. There is a **$25** charge for weekday appointments and **$50** charge for Saturday appointments if they are not canceled OR if 24-hour notice is not given.

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1. A **$35** fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.
2. We charge **$.75** per page to copy or transfer medical records.
3. If you have school, camp, disability, or sport forms to be completed, there is a **$10** charge per form. Payment is due when the forms are dropped off. We have a 3- to 5-day turnaround time for forms. If a form is needed sooner than 3 days, there is an additional **$10** *rush* fee.
4. Advance notice is needed for all non-emergent referrals, typically 3 to 5 business days. It is your responsibility to know if a selected specialist participates in your plan. Remember your primary care physician must approve referrals before being issued.
5. Before making an annual physical appointment, check with your insurance company whether the visit will be covered as a healthy visit. Not all plans cover annual healthy physicals or hearing and vision screenings. It is your responsibility to know your insurance plan benefits. If it is not covered, you will be responsible for payment at the time of visit.
6. Not all services provided by our office are covered by every plan. Any service determined to not be covered by your plan will be your responsibility.

I have read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name(s) _____

_____ _____

Responsible party member's name Relationship

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Our financial policy

Dear Patient,

Innovative HealthCare Physicians PC is dedicated to providing the highest level of medical care for you and we want you to completely understand our financial policies.

We have made prior arrangements with several insurance companies and other health plans to accept an assignment of benefits. As a service & convenience to you, we will file your insurance claim.

Payment is due at the time of service unless arrangements have been made in advance by your carrier.

Please understand that your insurance policy is a contract between *you and your insurance company*. *You* are responsible for the balance due as possibly a Copay Deductible, Coin-insurance or % of coverage.

A valid credit card is REQUIRED for ALL PREGNANT patients, no exceptions.

In order for our office to run smoothly we respectfully request that you sign the authorization below.

Thank you for your cooperation

Credit Card Information

☐ I authorize IHP to charge my credit card for the balance of charges not paid or covered by my insurance.

Name of the card holder : _____

Visa ☐ MasterCard ☐ Discovery ☐ American Express

Credit Card # _____ Expiration date _____ CVV _____

☐

I don't want to provide any information. I acknowledge that after receiving the first billing statement I have 10 business days to pay my balance. If no payment or arrangement can be reached after 30 days IHP will place the outstanding balance with our collection agency NCSPlus Incorporated and a $25 processing fee will incur.

Name (Please Print Clearly): _____

Signature: _____ Date: _____

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Pharmacy Information

Please list the Pharmacy you would like us to send your prescriptions to:

Name of Pharmacy _____

Address: _____

Pharmacy Phone # _____

Pharmacy Fax # _____

IHP 225 Broadway Suite 901 New York, NY 10007 Phone 212 393 9400 Fax 212 393 9405