InvisionHealth

Financial and Release of Records Policies
Agreement and Acknowledgement

- **Insurance co-pays are due at the time of your appointment.** Your insurance policies may require you to make a co-payment or pay a deductible for an office visit, a diagnostic test and/or a procedure; therefore payment is expected on the date of service.
- A $5.00 service fee will be charged if the co-pay is not paid at the time of service. There will be a $10.00 late fee for co-payments not made within 10 days of the date of service.
- Our office accepts many health care plans. We will bill those plans with which we have an agreement and collect co-pays at the time of service. In the event that your insurer determines the service is *"not covered"* by the terms of your health care plan, you will be responsible for payment in full *on the date of service*(s) to include office visits, procedures and in-patient surgical procedures.
- In the event that our physician(s) are not enrolled with your health care plan, you will be responsible for payment in full *on the date of service*(s). In this instance, you may submit your claim directly to your carrier to request reimbursement.
- In the event that your medical expenses will not be submitted to an insurance carrier, payment is due at the time of service to include office visits, procedures and in *advance* of any surgical procedures.
- **Many insurance companies require an authorization for visits to receive full benefit coverage.** If you are unsure if authorization is required, please call your insurance carrier directly. If required, the authorization must be received before your visit. Failure to provide us with the proper authorization may result in the rescheduling and/or cancellation of your appointment.
- **For appointments that are missed and not cancelled at least 24 hours prior to the scheduled office visit, there will be a no-show fee charged:**
  $25 fee for a missed office visit with a physical therapist, chiropractor, medical massage therapist
  $100 fee for a missed office visit with a physician, physician assistant and/or for an infusion appointment
- Your medical records may be copied upon request and written authorization. The New York Legislature has determined that a reasonable fee for copying medical records is $.75 per page. This fee assessed and due upon request of records.
- Form fees are not covered by your insurance company. For each injury/problem, one form will be completed free of charge. Thereafter, there will be a $15 charge for each form. This is to be paid in advance.

Financial Agreement
I hereby assume full responsibility for all charges incurred for professional services rendered by Invision Health and its assistants, including 33 1/3% collection costs and 50% attorney fees, unless the services are deemed "paid in full" as a result of a contractual agreement between Invision Health and my insurer.

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Authorization for the Release of Information
I hereby authorize Invision Health to release any medical, psychiatric, infectious disease (including AIDS confidential information) or drug and/or alcohol related information to my referring physician and any insurance company with whom I have medical benefits for the purpose of filing a medical claim. I acknowledge that this authorization is valid until such time as all medical bills related to my treatment have been paid. I further understand that I can withdraw this consent for release of information at any time prior to this expiration date except to the extent that action has been taken in reliance hereon.

Group & Individual Insurance, Assignment of Benefits
I authorize my health insurance benefit plan to pay directly to Invision Health, the surgical and/or medical, if any, otherwise payable to me for their services as described on attached claim but not to exceed the charges for those services. I understand I am financially responsible to Invision Health charges not covered by this assignment.

Medicare, Claim Authorization and Payment Request
I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to either myself or to the party who accepts this assignment. Regulations pertaining to Medicare assignment of benefits apply.

- **I acknowledge that I have read and agree to the financial policy of Invision Health.**

- **I acknowledge that I have read and agree to the privacy policy of Invision Health.**

Print Name:_____Signature:_____Date:_____