



Thank you for choosing Integro Family Health as your medical care provider. We are committed to help meet your medical and health care needs. Your clear understanding of our policies specified below is essential to maintaining a professional relationship.

Patient Name: _____
(Please Print)

CONSENT FOR TREATMENT

I acknowledge and understand that, in representing myself for treatment and continuing medical care at Integro Family Health, I authorize and consent to the administration and performance of all tests and treatments which may be ordered by the physician (and/or designated assistant) and carried out by Integro personnel. Minors must be accompanied by a parent/legal guardian for medical care.

ASSIGNMENT OF BENEFITS

In consideration of these medical services, I hereby assign, transfer and set over to Integro Family Health all my rights, title and interest to medical reimbursement benefits under my insurance policy.

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION FOR PAYMENT

I authorize Integro Family Health to release medical information or copies of my medical record within a reasonable time frame to insurance companies, third-party payers, authorized agents, or claims review organizations in order to process a claim for payment on my behalf. This information may be disseminated to any and all employers' insurance companies or their designees who may provide coverage for medical charges and to comply with the requirements of any Professional Review Organizations. This authorization may be revoked in writing at any time.

PAYMENT POLICY AND AGREEMENT

I hereby assume full responsibility for and agree to pay all costs, charges and expenses incurred by the patient to Integro Family Health. I acknowledge and understand that this agreement constitutes a direct primary and personal undertaking by me and is not conditioned or contingent upon payment of any such costs, charges or expenses by any third party. And assignment of benefits of any insurance policy or medical reimbursement plan shall not be deemed waiver of the Provider's right to require payment directly from the undersigned. The Provider expressly reserves its right to require such payment. In the event that this obligation remains unpaid and requires referral for collection, the undersigned agrees to pay all costs of collection, including but not limited to reasonable attorney's fees.

I further acknowledge and understand that all deductibles, co-pays, and outstanding balances are due at the time of service. For your convenience, payments can be made with cash, check, or Visa/Mastercard/American Express cards. Checks returned for insufficient funds will be charged \$35 fee.

Patients with medical insurance must present the insurance identification card along with a valid driver's license at the time of initial registration. We will also verify your insurance plan and personal information at every visit. If you are unable to present proof of insurance at the time of your visit, you will be considered Self-Pay and payment will be expected at the time of service. For Self-Pay patients, we offer 10% discount if full payment is made at the time of your visit. Our charges are usual and customary for our geographic area. You are responsible for payment regardless of any insurance company's determination of usual and customary rates, unless we have a participating agreement with that company.

I also understand that I am responsible for providing Integro Family Health with the most current personal and insurance information (i.e., changes in address, insurance, phone numbers, etc.).

We ask that you contact our business office directly for any insurance, billing or payment issues you may have. Their phone number is (630) 933-2701.

FAILED/MISSED APPOINTMENT POLICY

We have a 24-hour cancellation policy in effect for all appointments. If you foresee a scheduling conflict, we require that you either cancel or reschedule your appointment within that timeframe. Otherwise, the following fees will be charged and billed to your account:

\$100 for comprehensive physicals examinations
\$50 for all other failed/missed appointments

MEDICATION REFILL POLICY

If you need a prescription refill, please call your pharmacy and ask that they fax the request to us. Our fax number is (630) 462-9813. It may take up to two business days to process medication refill requests.

By signing below I acknowledge and consent to the policies of Integro Family as specified above.

Signature _____ Date _____
Patient / Parent or Guardian (if under 18 years of age)

Witness _____ Date _____