STATEMENT OF FINANCIAL RESPONSIBILITY, ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION

I acknowledge that I am responsible for all charges for Internal Medicine of Arizona services provided to me, including any amount not paid by my insurance plan, Medicare or other health service plans.

If my health insurance will not allow direct payment to IMA or if IMA chooses not to accept assignment of medical benefits, I agree to make payment to IMA all health insurance payments I receive for care at IMA immediately upon receipt of such payments. I understand that IMA has the right to refuse or accept assignment of medical benefits.

I also authorize IMA to release all medical information including, but not limited to, information relating to the diagnosis and treatment of psychiatric conditions, sickle cell anemia, alcohol and drug abuse and HIV or communicable diseases, if any such information exists, necessary for processing insurance claims to my insurers, the Health care financing administration (Medicare) or any other third-party payer or their agents.

I authorize IMA to contact my insurance company, health plan administrator or other third-party payer and obtain all pertinent financial information concerning coverage and payments made under my policy. I direct the insurance company, health plan administrator or third party payer and obtain all pertinent financial information concerning coverage and payments made under my policy. I direct the insurance company, health plan administrator or other third party payer to release such information to IMA. I agree that these provisions will remain in effect until otherwise revoked by me.

I understand that I must notify IMA if my illness or injury is work related prior to receiving any care. If I fail to notify IMA my claims will not be sent to the workers compensation carrier and I will be responsible for any charges. IMA will not file claims with the Worker's Compensation carrier if notified after care has been provided.

STATEMENT OF RIGHT TO A LIVING WILL/ADVANCED MEDICAL DIRECTIVES

I understand IMA recognizes a patient's right to accept or refuse medical treatment and their right to have a Living Will, Medical Power of Attorney or other form of advance written directive which serves as written instructions for the provision of health care in the event the patient becomes incapable of making their own medical decisions. I understand if I have any type of advance written directive, a copy should be given to IMA so that it can be placed in my medical record.

POLICY REGARDING OUTSIDE MEDICAL RECORDS AND RADIOLOGY FILMS

IMA will accept and may review written medical records, radiology films, or other materials from another healthcare institution if related to your care at IMA. At the completion of your episode of care IMA discards the remainder to the material unless otherwise directed by you. Medical record information mailed directly to IMA from may not be released to you without authorization. For radiology films that you bring to IMA please notify your physician and request their return prior to leaving. Films directly mailed to IMA by another healthcare institution will be returned by mail. I authorize IMA to request medical records, x-ray, labs and other tests from outside facilities for the purpose of medical treatment.

Patient Signature: _____ Date: _____

STATEMENT OF FINANCIAL RESPONSIBILITIY AND AUTHORIZATOIN TO RELEASE INFORMATION BY REPRESENTATIVE-IF OTHER THAN PATIENT:

I acknowledge that I am responsible for all charges for Internal Medicine of Arizona services provided to:

Patient Name: _____
Please Print

And authorize Internal Medicine of Arizona to proceed as stated above:

Signature: _____
Parent, Guardian, or Representative