INGLESIDE
MEDICAL ASSOCIATES
200 Municipal Drive, Thorndale PA 19372
P:610.383.6300 F:610.383.0114

Welcome to Ingleside Medical Associates
Office Policies

Please get to know us:

1. We are a Family Practice with six board certified physicians and two certified physician assistants.
2. We **enjoy treating patients of all ages**, from infant through maturity.
3. Our **convenient office hours** are Monday - Thursday, 8 am to 9 pm and Friday 8 am to 5 pm. In addition, we have appointments available Saturday mornings starting at 8 am for your convenience.
4. We have **two locations** to better serve your family's medical needs, with offices in Thorndale and Parkesburg.
5. We provide a **wide scope of services**, including our in-office laboratory, X-rays, minor surgeries, laceration repair, allergy shots, cosmetic procedures, osteopathic manual therapies, routine gynecologic care, as well as on site nursing home and hospital care.
6. We do all we can to stay on schedule, but medical emergencies may come up which require urgent attention. Therefore, we may be behind schedule at times. We appreciate your understanding.
7. Likewise, we would appreciate your timely arrival for appointments. We will attempt to accommodate you if you arrive late, but there may be times when we will need to reschedule your appointment. If you are more than 15 min late for an appointment it will need to be rescheduled.
8. We ask you to please give us a **48-hour** notice for your prescription refills, and a **72-hour** notice for any forms or documents you need filled out by the doctor. This is necessary because the physician responsible for prescribing your medication or completing your forms may be out of the office at the time of your request.
9. We do use all available appointments. Therefore, out of fairness to all our patients, we do track all missed or canceled appointments. We **require 24-hour notice** if you are not able to make your scheduled appointment. After the first occurrence, a $75.00 charge will be applied per instance. Additional details are in the Financial Policy.

My signature certifies I have read and understand the above policies and that the Financial Policy and Privacy Policy have been made available to me. All current policies are posted in the office, available upon request, and on the IMA website. (www.inglesidemedical.com)

_____ _____
Printed Name of Patient Date of Birth

_____ _____
Signature of Patient or Legal Guardian Todays Date

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Patient Information Form

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone #: _____ Secondary Phone #: _____

Date of Birth: _____/_____/_____ Social Security #: _____

E Mail Address: _____

Web Portal privileges are standard for all patients. Please check here to Decline: _____

Your Local Pharmacy: _____ Mail Order: _____

Person to Contact in the Event of an Emergency:

Name: _____ Relationship: _____

Phone #: _____ Alternate Phone #: _____

Appointment Reminders:
Your doctor and members of our medical staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone, and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

Note: Please give all your medical insurance, motor vehicle or workman's comp insurance information to the front desk with this form after completion. We must have this information at the time of your visit, or you may be asked to reschedule your appointment.

I authorize payment directly to the physician or supplier for the services described and further authorizes the release of information to my insurance carriers to process claim. If you do not have insurance or we do not have your current insurance information, you must pay for today's visit in full. If you have a balance on your account, you will be asked for payment today.

_____ _____
Signature of Patient or Legal Guardian Today's Date

AUTHORIZATION TO OBTAIN/RELEASE HEALTHCARE INFORMATION

INGLESIDE MEDICAL ASSOCIATES

200 Municipal Drive, Thorndale, PA, 19372 Phone: 610-383-6300 Fax: 610-383-0114

Patient Name: _____ Date of Birth: ____/____/_____

Phone Number: _____

I give permission to Ingleside Medical Associates to: (Please check one)

☐ OBTAIN ☐ RELEASE

My personal healthcare information from/to current Physician:

Dr: _____

Address: _____ City: _____State: ____

Zip Code: _____Phone: _____ Fax: _____

Information to be released (please check one):

☐ Entire Patient Chart

☐ Most recent 2 years of patient information (chart notes, labs, x-rays, and special tests)

☐ Specific Information (please specify) _____

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDs, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

EXCLUDE the following information from the records release (please initial):

_____ Drug/Alcohol Abuse/Treatment & Diagnosis
_____ Sexually Transmitted Disease
_____ HIV/AIDS Diagnosis/Treatment/Testing
_____ Mental Illness or Psychiatric Diagnosis/Treatment

_____ _____

Signature of Patient/Legal Guardian Todays Date

****Medical Records Request: Do not fax over 50 pages. If over 50 pages, please mail a disk.**

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AUTHORIZATION TO DISCUSS MEDICAL HISTORY

This form is optional.

You may choose to authorize any individual(s) to which your health care information is released or discussed. You may revoke your authorization at any time; however, your revocations must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive you your request to revoke your authorization.

I hereby authorize you to discuss or release any of my information to the following: (such as spouse, parent, family member)

Name	Relationship
_____	_____
_____	_____
_____	_____

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDs, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

EXCLUDE the following information from the records release (please initial):

_____ Drug/Alcohol Abuse/Treatment & Diagnosis

_____ Sexually Transmitted Disease

_____ HIV/AIDS Diagnosis/Treatment/Testing

_____ Mental Illness or Psychiatric Diagnosis/Treatment

Based on the authorization you are giving us, information that we use or disclose may be subject to redisclosure by anyone who has access to information and may no longer be protected by the Federal Privacy Rules.

I authorize you to use or disclose my health information in the manner described above.

_____ _____
Printed Name of Patient Date of Birth

_____ _____
Signature of Patient Todays Date

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PRIVACY POLICY

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This notice takes effect on July 1, 2023, and remains in effect until we replace it.

I. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal, and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This policy will tell you about the ways we may use and share your medical information. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

II. OUR LEGAL DUTY

The law requires us to:

- Keep your medical information private.
- Give you this notice describing our legal duties, privacy policies, and your rights regarding your medical information.
- Follow the terms of the notice that is now in effect.

We have the right to:

- Change our privacy policies and the terms of this notice at any time, provided that the law permits the changes.
- Make the changes in our privacy policies and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of change to PRIVACY POLICY:

- Before we make an important change in our privacy policy, we will change this notice and make the new notice available upon request.

III. USE AND DISCLOSURE OF YOUR MEDICAL INFORMAITON

The following sections describe different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed some of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below without your specific written authorization. Any specific written authorization you provide may be revoked at any time by providing a request to the office in writing.

For treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

For payment: We may use and disclose your medical information for payment purposes, such as insurance carriers, employers, motor vehicle insurance carriers, and workers' compensation carriers if they are potentially responsible for the payment of your services.

Notification: We may use your medical information to notify or help notify a family member, your personal representative, or another person responsible for your care. We may share information about your location, general condition, or death. If you are present and able to provide permission, we will get your permission before sharing information, or give you the opportunity to refuse permission. In case of an emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care

according to our professional judgement. We will also use our professional judgement to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-rays, or medical information for you.

Research in limited circumstances: Medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director and organ procurement organization: We may share the medical information of a person who has died with the funeral director or an organ procurement organization so that they may carry out their duties.

Court Orders: Under certain circumstances we may disclose medical information in response to a court or administrative order, subpoena, or other lawful process.

Workers' compensation and motor vehicle accidents: We may disclose health information when authorized and necessary to comply with laws relating to workers' compensation, motor vehicle accidents, or other authorized activities.

IV. YOUR INDIVIDUAL RIGHTS

You may:

- Look at or get copies of your medical information. You must make your request in writing.
- Receive a list of the times we shared your medical information for purposes other than treatment, payment, and other specified exceptions.
- Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
- Request that we correct your medical information. You may request that we correct your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including any people you name, of the change and to include the changes in any future sharing of that information.

V. Questions and Complaints

If you have any questions about this notice or if you think that we may have violated your privacy right, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services Regional Manager; 150 S Independence Mall W., Suite 372, Public Ledger Bldg., Philadelphia, Pa 19106-9111. We will not retaliate in any way if you choose to file a complaint.

VI. Amendments to this policy

IMA reserves the right to amend this policy at any time. Each version of the policy will have an effective date on the first page. IMA reserves the right to make the amended policy effective at the time the amendment is made. IMA will post a copy of the current policy on the IMA website, inglesidemedical.com as well as in the registration area of both the Thorndale and Parkesburg offices, when substantial changes are made.

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FINANCIAL POLICY

I. **PAYMENT** is expected at check-in at the start of your visit. We accept cash, check, or credit cards for payment. Payment due may include any unmet deductibles, co-insurances, co-payment amounts, or non-covered charges from your insurance company. If you do not carry insurance, payment in full is expected at the time of your visit. We also ask for a copy of an ID card or license if not on record.

II. **INSURANCE** We are participating providers with many insurance plans. Please remember that insurance is a contract between the patient and the insurance company. Ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable period of time you will be billed. If we later receive payment from your insurer, we will refund any overpayment to you. If our doctors are not listed in your plan's network, you may be responsible for partial or full payment. If you are insured by a plan with which we do not participate, you will be considered uninsured and will have to pay for all charges at the time of your visit. Due to the many different insurance products out there, our staff cannot guarantee your eligibility and coverage. Be sure to check with your insurer's member benefits department about services and physicians before your appointment. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

III. **RETURNED CHECKS** will incur a $35.00 service charge. You will be asked to bring cash, credit card, or a money order to cover the amount of the check plus the $35 service charge to pay the balance prior to receiving services from our staff or the physician. Stop payments constitute a breach of payment and are also subject to the $35 service fee.

IV. **FORM FEES** Completing insurance forms, copying medical records, etc., requires office staff time and time away from patient care for our doctors. We require payment for completing forms, copying medical records, or for extra written communication by the doctor. The charge is determined by the complexity of the form, letter, or communication. Basic form charges are $10-25 per occurrence, depending on the form. It may take at least 15 business days in which to copy records before making them available for patient to pick up, and these 15 days will commence after patient has signed the form authorizing the records' release.

V. **CANCELLATIONS OR MISSED APPOINTMENTS** If you have a scheduled appointment and do not show up or if you cancel your appointment with less than 24 hours advanced notice our policy is as follows:

THIS POLICY IS AVAILABLE ON THE IMA WEBSITE OR IN WRITING UPON REQUEST

- You will not be charged for the first missed appointment **in a calendar year**. In the event of an actual emergency in which prior notice could not be given, a one-time exception MAY be granted at the discretion of the provider.
- You will be charged a $75 fee upon the second occurrence, which must be paid prior to scheduling any additional appointments.

VI. **ACCOUNTING PRINCIPALS** Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.

VII. **SELF PAY PATIENTS OR PATIENTS WHO ARE CONSIDERED UNINSURED** All services are expected to be paid in full at the time of service. You will be charged up front at check-in for any unpaid balances before a self-pay deduction can be applied. By paying at the time of service, and therefore decreasing administrative costs, we are able to offer 30% off office visits, in-house labs, and procedures. We can give you an estimated cost on labs, procedures, or tests prior to your services of such lab, test, or procedure.

VIII. **COLLECTIONS** I understand that in the event my account is placed in collection status I am required and expected to make a payment on my outstanding balance at check-in prior to being seen by the physician or nurse. I understand that failure to make a payment toward my outstanding balance may result in having to reschedule my appointment to a time of which I can make a payment. I understand that Ingleside Medical Associates has the right to reschedule or refuse treatment if my account is not in good standing.

IX. **DIVORCED PARENTS of PATIENTS** By signing below, the adult who signs a minor child into our practice accepts responsibility for payment. This office does not promise to send bills or records to the other parent/guardian for issues of payment or communication. We will communicate about treatment and payment with the parent who signs this financial policy. Parents are responsible between themselves to communicate with each other about the treatment and payment issues.

X. **AMENDMENTS TO THIS POLICY** IMA reserves the right to amend this Notice at any time. Each version of the Notice will have an effective date on the bottom of the page. IMA reserves the right to make the amended Notice effective at the time the amendment is made. IMA will post a copy of the current Notice on the IMA website, inglesidemedical.com as well as in the registration area of both the Thorndale and Parkesburg offices, when substantial changes are made.

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