



INTEGRATIVE PRACTICE SOLUTIONS
PHYSICIAN SERVICES

MEDICAL BILLING SERVICES

- **NO** START UP FEES
- **NO** EARLY TERMINATION FEES
- **NO** MONTHLY MINIMUMS

NO EXCUSES!

Say Goodbye to Medical Billing Headaches

Delay in reimbursements due to late or unsubmitted insurance claims paralyze a clinic's business operations. Insurance audits take practitioners and staff away from billable patient time, and often means overtime costs. Insurance pay backs can result in clinic closure or staff layoffs.

FINALLY!

A Medical Billing Service That Makes Sense

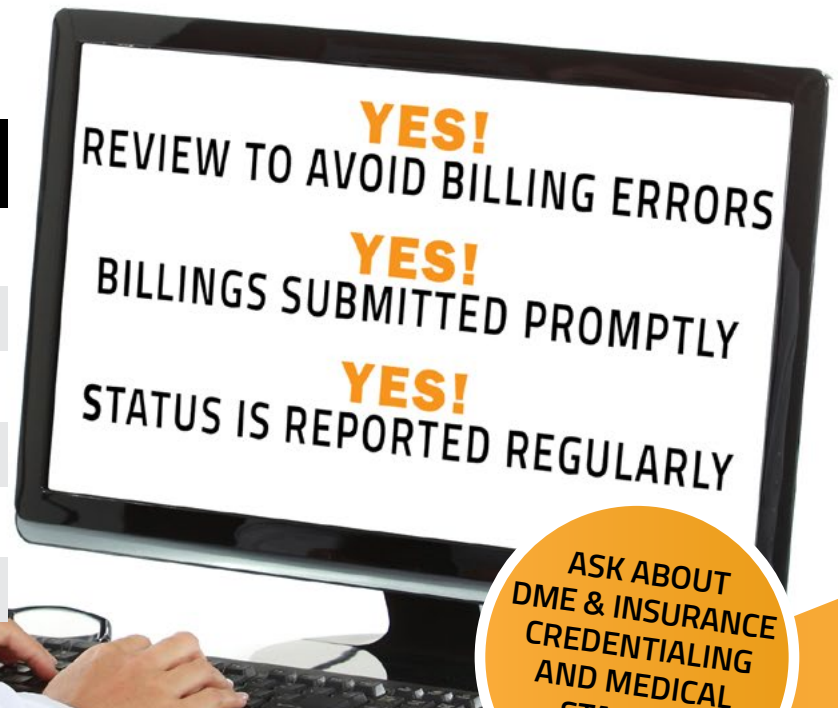
Hiring IPS to manage your medical billing, allows access to our team of experts who are empowered to "do it right". Enjoy the usual high service level from IPS as an expanded service for your practice. Our month-to-month medical billing service is offered at an extremely reasonable rate as compared to other billing companies.

After intervening with several medical billing services on behalf of our clients, and experience running clinic operations, it became clear it was time to expand IPS services to meet this demand with excellence.

REASONABLE RATES

Description	Charge*
Collections Billing Fee (Gross)	6%
Insurance Verification	\$15
Insurance Prior Authorization	\$25
Start-Up or Implementation Fees	\$0
Early Termination Fees	\$0
Monthly Minimums	\$0

* Charges subject to change. Upon termination collections % fee survives for 90 days for claims submitted by IPS.



ASK ABOUT
DME & INSURANCE
CREDENTIALING
AND MEDICAL
STAFFING
SERVICES!

QUESTIONS? CALL: 855.854.6332

BILLING SERVICES ORDER

Yes! Please, sign up our organization up for IPS Physician Billing Services. Options available:

- Collections Billing Fee (Gross) @ 6%
- Insurance Verification @ \$15 each
- Insurance Prior Authorization @ \$25 each

Clinic Name: _____

LIST CLINICS FOR BILLING SERVICES

Address/Suite/City/State/Zip	Contact Name	Phone	Select Services
			<input type="checkbox"/> Billing <input type="checkbox"/> Verification <input type="checkbox"/> Prior Authorization
			<input type="checkbox"/> Billing <input type="checkbox"/> Verification <input type="checkbox"/> Prior Authorization
			<input type="checkbox"/> Billing <input type="checkbox"/> Verification <input type="checkbox"/> Prior Authorization
			<input type="checkbox"/> Billing <input type="checkbox"/> Verification <input type="checkbox"/> Prior Authorization

Credit Card Information

Cardholder's Name (as on card): _____

Cardholders Billing Address: _____

City: _____ State: _____ Zip: _____ Country: _____

Home Phone: _____ Fax: _____

Work Phone: _____ Email: _____

Type of Card: MasterCard Visa Discover American Express

Card Number: _____ Expiration Date: ____/____
(mm/yyyy)

Credit Card Security Code: _____ Amount to be Charged: \$ _____

I understand that my business/clinic will be assessed charges for services monthly as selected and I authorize IPS to apply charges to the credit card listed.

AUTHORIZED SIGNATURE

DATE

PRINT NAME

TITLE

PLEASE FAX COMPLETED FORM TO 727-683-9536