STANFORD
HOSPITAL & CLINICS
Stanford University Medical Center

International Medical Services
300 Pasteur Drive, Room H1111
Stanford, CA 94305-5242
Tel: (650) 723-8561
Fax: (650) 723-5704

IMS Patient Financial Policy

1. You will be provided with a written estimate of charges as soon as a treatment plan is available. IMS endeavors to provide its clients with the most accurate estimates possible. However, it is understood that your final charges will depend on the actual services received and may therefore significantly exceed our estimates.

2. An initial deposit is required prior to services being provided. The initial deposit will be 100% of our estimate of total charges.

3. All payments are expected to be made in U.S. dollars. IMS accepts VISA, MasterCard, American Express and Discover. Personal and cashiers checks are also acceptable when written on a U.S. Bank. No checks written on banks outside the U.S. will be accepted without prior approval.

4. During your course of treatment, additional deposits will be required if your charges significantly exceed our estimates.

5. Prior to leaving, you will be provided a summary statement of your accounts, reflecting all current charges and deposits. You will be requested to provide payment in full on all charges exceeding your deposits at that time.

6. A final billing statement will be completed and forwarded to you twenty (20) days following the completion of your treatment. Itemized statements detailing the specific services provided by the Stanford Medical Center will be furnished at that time. It is important to note: your itemized statements may reflect charges that were not submitted for payment at the time of your departure. Payment of the final bill is due within fifteen (15) days of receipt.

7. A refund check will be mailed within two weeks of our final billing statement for any account whose deposit amount exceeds the actual charges. If your initial deposit was provided on VISA, MasterCard, American Express or Discover, your refund will be credited directly to that account. Refunds of this nature are processed immediately.

The undersigned certifies that he/she has read the foregoing and agrees to its terms:

_____ _____

Patient or Representative Date

_____ _____

Witness Date