Patient Financial Agreement, Cancellation Policy, HIPAA Acknowledgement

Dear Patient,

We want you to have a clear understanding of our policy concerning payment and Insurance. Our Office accepts cash, checks, Visa and MasterCard.

If you have NO INSURANCE you will need to pay your charges in full on each visit.

Many Insurance policies do cover acupuncture care but this office makes no representation that yours does. Insurance policies may vary greatly in terms of deductible and percentage of coverage for acupuncture care. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balances in this office. We will do our best to verify your insurance coverage, and will bill your insurance in a timely manner. If we receive notification that you are not eligible for coverage or we are not contracted with your insurance, you will be responsible for all charges incurred. We will notify you of any amounts your insurance fails to pay within sixty (60) days. You will have another thirty (30) days to call your insurance company. Any amount owing over ninety (90) days by your insurance company will be your responsibility. All copays, deductibles and coinsurance are due at the time of service.

If you suspend or terminate your care at any time, your portion of all charges for professional services is immediately due and payable to this office. All services rendered by this office are charged directly to you, and you, ultimately will be responsible for payment regardless of your insurance coverage.

If at any time you should experience financial hardship and need to make special arrangements, please contact our office.

CANCELLATION POLICY

While understanding there may be times when you miss an appointment, due to emergencies or obligations. Our office requires at least a 24 hour notice on all cancelled appointments. In order to cancel your appointment and put another patient in your time slot, we require a phone call to the office at least 24 hours in advance, and a voice mail is acceptable.

Please note that a $50 cancellation fee will apply for missed appointments or failure to cancel within 24 hours. We have retained your credit card in order to make your first appointment. By signing this agreement, you authorize the rendering provider to charge your credit card for not showing up for your appointment or cancelling your appointment with less than a 24 hour notice. These fees must be made prior to your next appointment. Also by signing this agreement, you authorize the rendering provider to charge your card for any 90 day outstanding balance.

HIPAA ACKNOWLEDGEMENT

No information regarding our patients is shared or distributed with any other person or organization without the patient's signed authorization. Your signature below acknowledges receipt of our privacy policy information statement.

I have read and understand the above statements. I agree to comply with the policies of the office and I am financially responsible for my account.

Patient or guardian signature: _____ Date: _____

Print Patient Name:_____ Date of Birth:_____