MISTY MOUNTAIN ACUPUNCTURE AND HEALING CENTER

FINANCIAL AGREEMENT

It is our goal for patients to clearly understand their financial responsibility before their treatment begins. We want to make your financial responsibility as easy as possible. Therefore, we offer the following financial agreements.

1. Patients with insurance: Estimated portion not covered is due at time of service.
2. Patients without insurance: Payment is due at the time of service.
3. Patients with treatments related to an accident must inform Misty Mountain Acupuncture at the time of their first appointment.
4. Balances due that are not paid within 90 days will be sent to collections.
5. A 1.5% service charge will be attached to unpaid balances past 30 days

I HAVE READ AND UNDERSTAND THESE POLICIES AND MY RESPONSIBILITY CONCERNING THE PAYMENT OF THESE SERVICES.

Patient Signature: _____ Date: _____

PATIENTS WITH INSURANCE:

- As a courtesy we bill your insurance carrier. However, it must be understood that the contract is between you and your insurance carrier and you are fully responsible for any amount that they do not pay.
- Our office does not guarantee that your insurance will pay. Some insurance companies do not cover acupuncture. We will assist you, if necessary, in making every attempt to receive verification of your policy. If for any reason your claim is denied, you are responsible for the full amount of your bill.
- Our office will not enter into a dispute with your insurance company over any unpaid claim.
- If your insurance requires a referral from your primary care physician for treatment, you will be responsible for payment of all services until our office has received a hard copy of the referral. If at a later date your insurance reimburses for services that you paid for at the time of the visit, that amount will be refunded to you.
- Failure to provide us with adequate information regarding your insurance may result in a denial from your insurance carrier and you will be responsible for and unpaid balance. Please make sure that we have all the necessary information to process your claim.

BY SIGNING BELOW, YOU ARE ACKNOWLEDGING YOU UNDERSTANDING OF THE OFFICE POLICIES DESCRIBED ABOVE.

Print Patient's Name: _____

Patient's Signature: _____ Date: _____

ASSIGNMENT AND RELEASE: I hereby authorize my benefits to be paid directly to Misty Mountain Acupuncture and Healing Center. I am financially responsible for any balance due. I also authorize the practitioner listed to release any information required for this claim.

Patient's Signature: _____