

# Acupuncture for Pregnancy Financial Agreement

340 15<sup>th</sup> Ave East  
Seattle, WA 98112

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

1. Patients with insurance: Co-pay is due at time of service.
2. Patients without insurance: Payment is due at the time of service.
3. Patients with treatment related to an accident must inform Acupuncture for Pregnancy at the time of the first appointment.
4. A 1% 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 including deductibles and co-insurance.
- 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 any unpaid balance. Please make sure that we have all the necessary information to process your claim.
- A copy of our fee schedule is available upon request.

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

Print Patient's Name: \_\_\_\_\_.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_.

ASSIGNMENT AND RELEASE: I hereby authorize my benefits to be paid directly to Acupuncture for Pregnancy. I am financially responsible for any balance due. I also authorize the practitioner(s) listed to release any information required for this claim.

Patient Signature: \_\_\_\_\_.