FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which we require you to read and sign prior to any treatment.

Fees:

Our fees are determined by the complexity of each case and different services used.

Regarding insurance:

We will verify coverage prior to treatment, and we will file all claims as a courtesy to you. If for any reason we are not able to verify coverage prior to your treatment, you will be charged for the treatment until verification is obtained. We cannot bill your insurance unless you bring us all necessary insurance information. We are not a party to that contract. By signing this document, you are assigning to this office the benefits to which you are eligible to receive for care rendered in this office. Additionally, in signing this document you authorize the release of any information to any insurance company, adjuster or attorney that will assist in the payment of a claim. We request a credit card on file if the insurance company should not pay claims or any balances owed should there be any difference in the amount owed.

Usual and Customary Rates UCR:

Our practice is committed to providing the best treatment possible for our patients. We charge what is usual and customary for our area. Please be aware that some and at times perhaps all of the services may be non-covered services and not considered reasonable and necessary by medical insurance. All payments are due at the time of service.

____

PATIENT'S SIGNATURE

____

DATE

FINANCIAL POLICY

OFFICE FINANCIAL POLICY AND AUTHORIZATION TO BILL INSURANCE

There are two billing options available for you. Please select the one you prefer us to use for your visits. If at any time if you choose to change your billing option, you are required to let us know immediately and sign a new Office Financial Policy and Authorization to Bill Insurance Form.

_____ Private Pay

Private Pay patients are patients that do not bill insurance. Payment is due at the time the services are rendered. We accept cash and all major credit cards, FSA and HSA. We DO NOT accept checks.

______ Insurance Billing (Medical Insurance)

I understand that I must pay all co-payments and/or co-insurances not covered by my insurance company at the time of check in for today's visit, and every visit hereafter. Three Moons Acupuncture will submit my claim for me to my insurance company. Although Three Moons Acupuncture verifies my insurance; **I understand that this verification is not a guarantee of payment**. I understand that any and all charges incurred at this office including co-payment, coinsurance, percentage due and/or deductibles or any other fees or services not covered by my insurance company are my responsibility. **I understand that if these patient portions due are not paid at the time of service I will be subject to a $10.00 billing fee per month – no exceptions until the outstanding amounts are paid**. I further understand that any unpaid balance **over 90 days**, can and will be sent to collections for recovery unless prior arrangements have been made. I authorize my insurance benefits to be paid directly to Three Moons Acupuncture. I also authorize the provider to release any information and medical records required by my insurance company. I understand that I may revoke this consent by written request, at any time. No other records shall be released without my signed consent.

____ ______________________________

Signature of Responsible Party Date

____ ______________________________

Signature of Person Authorized to Consent Date

CANCELLATION & RESCHEDULING POLICY

Cancel/Reschedule Appointments:

Your appointment time is reserved specifically for you. **If you need to cancel or reschedule your appointment, please do so at least 24 hours before your scheduled appointment time.** Changes can be made online using the link in your confirmation email, or by calling us at 262-977-8793.

All appointments (including new patient appointments) needing to be cancelled or rescheduled with less than 24 hours advance notice will be charged 50% of the regular appointment fee to the card on file. This includes appointments that are made as part of a package.

Missed Appointments:

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointment at the rate of a normal office visit if you are a repeat offender of this rule. Your treatments will be more effective if you follow your treatment guidelines and adhere to your schedule. Please help us to serve you better by keeping your scheduled appointments. Please let us know if you have any questions or concerns.

If you are **15 minutes late** to your scheduled appointment, you will not be treated that day and your appointment must be rescheduled.

A no call / no show: will result in a charge for the missed appointment at the rate of normal service charge.
A no call / no show charge must be paid before another appointment will be scheduled or administered.
After 3 no call / no show's: the patient may be terminated.

Appointments are considered cancelled and forfeited 20 minutes after the appointment time without advance notice and charged to the card on file per the policy. Please contact us at 262-977-8793 if you are running late.

Emergencies and certain exceptions can be made on a case-by-case basis but must be done by phone before the appointment.
I have read the cancellation and rescheduling policy and I agree to this policy.

_______________________________________ _____________________________

Signature of Responsible Party Date

_______________________________________ _____________________________

Signature of Person Authorized to Consent Date