North Florida Acupuncture Inc.

FINANCIAL POLICY

Thank you for choosing us as your health care 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.

Full payment is due at time of service.
We accept cash, check, or credit cards via paypal on our website

Insurance

Your insurance policy is a contract between you and your insurance company. We are not party to that contract. Any balance due on your treatments is your responsibility whether your insurance company pays or not.

You will be charged for each visit until verification of your insurance coverage is obtained. Our fees are determined by the complexity of the particular case and the different services used during treatment. ***In 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 payment of a claim.***

In the event we do not accept assignment of benefits, we require that you provide a credit card number with authorization to bill that account for any balance your insurance company does not pay. If your insurance company has not paid your account in full within 45 days, the balance of your account will be automatically transferred to your credit card. We cannot bill your insurance company unless you bring in all insurance information.

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 and expertise. Please be aware that some, at times perhaps all, of the services provided may be “non-covered” services and not considered reasonable and necessary under the Medicare program and/or by other medical insurance. You are responsible for payment in full regardless of any insurance company's arbitrary determination of usual and customary rates.

Missed Appointments

Please give 24 hours notice for canceled appointments. Cancellations with less than 24 hours notice are considered missed appointments. ***We usually do not charge a fee for the first missed appointment, however, subsequent missed appointments will be charged a $30.00 cancellation fee.*** If missed appointments become excessive and problematic, we reserve the right to discharge the patient from our services.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.
A photocopy of this form shall be considered as effective as the original.

______________________________________ _______________
Signature of Patient or Responsible Party Date

North Florida Acupuncture Inc.

Payment at Time of Service

In an effort to minimize costs and create the best possible atmosphere for healing, we have made the following adjustments to our Usual and Customary Rates. We are able to do this because ***payment at time of service frees this office from time consuming paper work and tracking of filed insurance claims.***

Patients are responsible for paying for office visits.

Office Visits		
E&M Billing Code	*Description*	*Fee*
99203.25	New Patient Office Visit	$85.00
99213.25	Returning Patient Office Visit	$60.00

When payment at time of service is rendered for office visits, any of the treatment procedures below will be included for a reduced fee of $0.00.

Treatment Procedures		
CPT Billing Code	*Description*	*Fee*
97810	Acupuncture Initial 15 min.	waived
97811	Acupuncture Second 15 min.	waived
97010	Heat Therapy	waived
97014	E-stim Unattended (TENS)	waived
97032	E-stim Attended (TENS, Laser)	waived
97813	E-stim Acupuncture initial 15 min	waived
97814	E-stim Acupuncture 2nd 15 min	waived
97140	Manual Therapy (Cupping, Guasha)	Waived
97124	Massage (Tuina Therapy)	waived
97530	Kinetic Activities	waived
97110	Therapeutic Exercise	waived

I have read and understand the information contained herein.

_______________________________________ _______________
Signature of Patient or Responsible Party Date