

Financial Policy Agreement

Green Point Acupuncture L.L.C.

1. This is a Financial Policy Agreement for *Green Point Acupuncture L.L.C.* (hereinafter referred to as “the clinic”), and serves as an agreement with the undersigned (hereinafter referred to as “patient”).
2. **The clinic provides acupuncture treatment to you, the patient. Payment is expected at the time of treatment, from patient, for all services and herbal prescription items, or when prescription is rendered, unless arrangements are made with the patient’s health insurance company. The clinic will accept payment in the forms of cash and checks only.**
3. Some insurance policies offer full or partial coverage for acupuncture care. In the case of practitioners not being the preferred providers, patient must make payment for all services and prescription items at the time service or the herb prescription is rendered. The clinic will provide the appropriate forms and codes for patient to file with the insurance company. **In the case of the practitioners being the preferred provider in a health insurance plan, patient must pay copay, deductible, coinsurance, or non-covered herbal supplements or other non-covered items at the time of the service.** In the case of insurance company denying a claim for coverage due to any reason, the patient is then responsible for all unpaid balances incurred.
4. If the patient’s bank or financial institution returns a check for any reason, a handling fee of \$25.00 will be assessed for each time the check is returned by the bank or financial institution.
5. The clinic reserves the right to bill patient’s bank or other negotiable instruments in the event of a delinquent account. Patient authorizes payment of delinquent account with bankcard, or other instrument.
6. Patient must inform the clinic of any changes in their appointment at least 24 hours ahead of time or a fee of \$25.00 will be charged.

I, _____ (patient name), have read the above statement of Financial Policy, and agree to all conditions of the agreement contained herein. No attempt to modify or amend this agreement will change its terms, or in any way be binding upon the clinic. I authorize the clinic to release appropriate billing information required for the filing of insurance claims.

Patient Signature
(Or Patient Representative)

Date
(Indicate relationship if signing for patient)

Clinic Signature

Date

This form will be retained in your medical record.