FINANCIAL POLICY

Harmony Acupuncture and Wellness, LLC

Karen Lin, Dipl.O.M; Dipl.Ac

FINANCIAL POLICY

Thank you for choosing us to provide you with medical care. We are committed to serving you with skill and care. The medical services by our office are services you have elected to receive which may result to a financial responsibility on your part.

CO-PAYS: Co-pays are due at the time of service.

SELF PAY: Payment in full is due at the time of service if you do not have health insurance.

PROOF OF INSURANCE: We require copies of your driver's license and current insurance card. If a current insurance card is not present, payment in full is required until insurance coverage can be verified.

PRIMARY INSURANCE: We may or may not be a participating provider for your insurance company. Your primary as well as your secondary insurance (if any) will be billed for you. You are responsible for co-payment for deductible amounts as stated by your insurance companies.

NON-COVERED SERVICES: Some services may not be covered or not considered reasonable/necessary by your insurance. Please contact your insurance company with any questions regarding coverage.

PATIENT BILLING: A statement of your financial responsibility (co-insurance, deductible) will be sent to you after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. You will be sent up to two notices. The first statement gives you 21 days to send payment. The second and last notice give you an additional 10 days. Your account may be forwarded to collections, thereafter. Please let the billing office know if you any difficulties resolving your bill. Payment arrangements can be made on a case by case basis. We accept the following payment methods: Cash, Check, Money Order, and Credit Cards.

An additional $35.00 will be added to your statement if the check is returned for insufficient funds.

In the event that your insurance company should happen to send payment to you, we expect that you would forward it to our office to be applied to your balance.

I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance information.

I have read the above policy regarding my financial responsibility to Harmony Acupuncture and Wellness, LLC for providing medical services to me or the below named patient. I agree to pay any amount due after payment has been made by my insurance carrier and any contractual adjustments have been credited **OR** the full amount of all bills incurred by me or my dependent if there is no health insurance coverage exists.

PRINT Patient Name: ____ **Signature:** ______________________________

FINANCIAL RESPONSIBILITY PARTY:

PRINT Name: ____ **Signature:** ______________________________

Relationship to Patient:____ **Date:** _________________________________