

HighPointHealthSeattle.com * Patient Financial Responsibility Form

Financial Responsibility: I understand that I am financially responsible for all charges incurred for my medical treatment. This includes, but is not limited to, co-pays, co-insurance, deductibles, and any charges not covered by my insurance.

Payment Terms: Co-pays are due at the time of service.

- I will provide accurate and updated insurance information as my insurance changes.
- I agree to pay any remaining balance after insurance has processed my claim.

Self-Pay Patients: If I do not have insurance or choose not to use my insurance, I agree to pay the self-pay rate for services rendered at the time of service. *Miranda can offer a time of service payment rate generally between \$145 - \$195 for first visit, \$95 - \$115 for follow up visits, \$50 comminty / ear.*

Additional Charges: I understand that I may incur additional charges for services not covered by my insurance, and I am responsible for these payments.

Authorization: By signing below, I authorize the assignment of financial benefits directly to the healthcare provider and acknowledge my financial responsibility for any charges not covered by insurance.

Signature: _____ Date: _____

Name (Printed) _____

We may verify your insurance coverage for you if we have your information in time before the appointment.

Insurance Verification (Optional)

High Point Health dba Jade River Acupuncture owner Miranda Taylor L.Ac
is set up for direct payment from certain plans within insurance companies.

Payment must be made in full when services are rendered unless your insurance has been verified.

The name of the person at your insurance plan who I spoke with: _____

Date called _____ Time called _____ *in case plan does not follow through, you may access the recording of your call.*

Is Miranda Taylor L.Ac in my plan's network? Yes ___ No ___
if not, are there out-of-network benefits? _____

Is there a co-pay or co-insurance? _____
What is the co-pay amount or co-insurance percentage? _____

What is my deductible? _____ If it hasn't been met, how much is remaining? _____