Marisol McManus, M.Ac., A. P.
8353 SW 124th St., Suite 103
Miami, FL 33156

Please fill in the following information as completely as possible. In order for us to verify your insurance benefits we must have the information listed below. This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

NAME____DATE_____________________

ADDRESS____

CITY/STATE/ZIP____

HOMEPHONE____________________CELLPHONE__________________________________

Date of Birth ____________________AGE_______ MARITAL STATUS__________________

PLACE OF EMPLOYMENT ____

WORK PHONE ________________________ EMAIL________________________________

May we leave messages from this office in your cellular phone _________ home _________
Email: _______________

Have you had an Auto Accident within the last two years? ___________Date: _____________

How did you first learn about acupuncture?____

Major Medical Complaint: ____

Current Medications (**include any supplements taken**):____________________________________

____

____

Surgical History:____

____

____

PRIMARY INSURANCE:

MEDICARE___WORKCOMP_____AUTO____HEALTH____ Company: __________________________

Please supply us with a copy of your insurance card.

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CONSENT TO TREATMENT

I, the undersigned, understand that methods of treatment used in this practice may include, but are not limited to, acupuncture, moxibustion, herbal therapy, massage, as well as lifestyle and nutritional counseling. I understand that acupuncture, moxibustion are safe methods of treatment but there may be temporary redness, soreness and/or bruising, although the clinic uses only sterile, disposable needles man maintains a safe and clean environment.

Treatment: I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments and are not a substitute for conventional medical diagnosis. I will notify my practitioner should I become pregnant or if I am in the process of trying to get pregnant.

I understand that herbal and nutritional supplements recommended to me by my acupuncturist are safe in the recommended doses. Large doses of herbs taken without my practitioner's recommendation may be toxic, and some herbs are inappropriate during pregnancy. Some possible side effects of herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that I must stop taking any herbs and notify my acupuncturist as soon as I experience any discomfort or adverse reactions.

I understand that my practitioner may review my medical records and lab reports, but all my records will be kept confidential. If it becomes necessary to share my health information, this will be handled in accordance with the stipulations detailed in the Notice of Privacy Practices document that has been provided to me, and of which I have acknowledged receipt.

I understand that I can discuss risks and benefits further with my practitioner before signing if I so choose. However, I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise his or her judgment in my best interest during the course of treatment, based upon the facts then known.

Cancellation of Appointments: I recognize that scheduling an appointment involves the reservation of time specifically for me, and that consequently, a minimum of 24 hours notice is required to reschedule or cancel an appointment. Unless otherwise agreed to in advance, there will be a fee charged for sessions missed without such advance notification

In signing this form, I acknowledge any inherent risks, and give my consent for treatment, payment and healthcare operations received, incurred or carried out at this practice.

____

Patient Signature Date

NOTICE OF PRIVACY PRACTICES AND PATIENT RIGHTS

I acknowledge that, as required by law, I have received a copy of the Notice of Privacy Practices and Patient Rights and I have had the opportunity to ask questions about it.

____

Patient Signature Date

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To: Patients Paying at the Time of Service – Fee Schedule Explanation

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 (UCR). We are able to do this because paying at time of service frees this office from time-consuming paper work and tracking of filed insurance claims.

When paying at the time of service you are responsible for the **patient office visit fee**. Your invoice will show the office visit and my fee.

If the visit is to be billed to your health insurance carrier, please note that you will be responsible for the office visit fee until your deductible has been covered. When submitting the claim to the insurance carriers, procedures have to be detailed in various codes, by the type of procedure and the time for each segment. The total amount billed to the insurance is the visit fee plus fees charged for those procedures/services provided. Alternatively, you may choose to pay the office visit fee, we will provide you with a "Super Bill" and you can claim from your insurance directly.

There are several procedures that may occur during your visit, and some of the codes utilized in the billing are:

97810-52	Acupuncture	1st 15 min
97811-52	Acupuncture	2nd 15 min
97010-52	Heat therapy	
97140-52	Manual Therapy	
97530-52	Kinetic Activities	
97110-52	Therapeutic Exercises	
99070-52	Needles	
20550	Acupoint Injection Therapy	
97026	Infrared heat therapy	

I have read and understand the information contained therein.

_______________________________________ Date__________
Patient's Signature

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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. All patients must complete our Patient Information sheet before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECKS, MASTERCARD, VISA AND AMERICAN EXPRESS

Regarding Insurance

We will verify coverage prior to treatment. Patients are required to pay for their visits until reimbursement is received from their insurance company. Our fees are determined by the complexity of the particular case and the different services used during treatment. Any balance due on your treatments is your responsibility whether your insurance company pays or not. Please note that the insurance policy is a contract between you and your insurance company. We are not party to that contract. 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. 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. By signing this document you authorize the release of any information to any insurance company, adjustor or attorney that will assist in the payment of a claim.

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 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

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Your treatments will be more effective if you follow your doctor’s guidelines and stick to your treatment schedule. Please help us to serve you better by keeping scheduled appointments.

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.

X____Date:________________________

Signature of Patient or Responsible Party

X____ Exp. Date: ______________ Validation # _____________

Credit card #