Health Partners Financial Disclosure

As your Acupuncturist, I want to provide you with the best care possible. While your policy covers some acupuncture services, there may be others that I feel would help the treatment of your condition and maintenance of good health, but are not covered by your health insurance coverage. If you agree to receive these services, and they are later determined to not be eligible for reimbursement through your health plan policy, your signature on this form signifies your agreement to pay for them in full. While you may choose to not obtain these services, I want to reassure you that I will only recommend care that I believe will benefit your health.

Acupuncture services typically covered by Health Partners policies include:

1. As an analgesia for medical procedure;
2. Chronic pain syndromes, including but not limited to:
   Neuromusculoskeletal conditions (eg. Neck, back, extremity pain, radicular syndromes, myofascial pain syndromes, fibromyaligia syndromes);
   Headaches (chronic or recurrent, tension or migraine)
3. Nausea (e.g. following chemotherapy, associated with pregnancy)
4. PMS or menstrual disorders

Treatment coverage is for 12 visits for the above conditions per calendar year. Prior authorization for patients with a new condition or restorative therapy is required. Patient will be required to fill out necessary paper work for the prior authorization process. The care must demonstrate improvement in quality of living indexes as indicated on the Health Partners website.

I have read and fully understand all of the information above. I also understand that the approved facility for care is the Maple Grove location and no services provided in the Crystal location are covered and are my financial responsibility.

Printed Name (First, Middle, Last): _____

Signature: _____ **Date**: ____/____/____

Benefits Assignment

I hereby authorize the assignment of benefits (payments) directly to Bonnie M. Abel Bolash, M.Ac., L.Ac. or legal representative for all my insurance claims related to services received. I agree to pay any and all charges that exceed, or are not covered by my insurance. I understand that co-payments, deductibles, and non-covered services are due in full at the time of service. I also give permission to release any medical records related to the service dates submitted or other records requested to substantiate the claim for reimbursement. In the event that services that were covered were then at a later date determined to not be a covered service I agree to pay for those services rendered.

Signature of Responsible Party: _____ **Date**: ____/____/____

Health Partners Policy Holder Name:_____**DOB:** ____/____/____

Health Partners Policy Number:_____**Group:**_____

Do Not Bill my Insurance: _____

Signature Date