Non participating Provider Financial Disclosure

As your Acupuncturist, I want to provide you with the best care possible. While your policy may or may not cover some acupuncture services if there is coverage it typically may cover chronic pain for limited conditions.

Name of Insurance:_____

Address:_____
City State Zip

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.

BCBS Policy Holder Name:_____**DOB:** ____/____/____

BCBS Policy Number:_____**Group:**_____

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