North Scottsdale Acupuncture
10250 N 92nd Street, Suite 301
Scottsdale, AZ 85258

FINANCIAL POLICY:

I understand that I am responsible to pay for any non-covered charges.

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

1. On arrival, please sign in at the front desk and present your current insurance card at every visit. You will be asked to sign and date the file copy of the card. This is your verification of the correct insurance and consent to bill on your behalf. IF THE INSURANCE COMPANY THAT YOU DESIGNATE IS INCORRECT, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THE VISIT AND TO SUBMIT THE CHARGES TO THE CORRECT PLAN.
2. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.
3. We do not submit to secondary insurance plans. If you have secondary insurance, we will provide you with a receipt to submit for reimbursement. Your secondary insurance will send the reimbursement check directly to you. YOU ARE RESPONSIBLE FOR ANY BALANCE ON YOUR ACCOUNT.
4. It is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see specialists, if preauthorization is required prior to a procedure, and what services are covered.
5. Acupuncture is billed as a specialist, if we do not participate in your insurance plan, payment in full is expected from you at the time of your office visit. You may request that we contract with your insurance in advance of your appointment.
6. If you have no insurance, payment for an office visit is to be paid at the time of the visit.
7. Co-payments are due at time of service.
8. Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. We will bill the credit card on file at that time.
9. If previous arrangements have not been made with our finance office, any account balance outstanding greater than 28 days will be charged a $10 re-bill fee. Any balance over 60 days will be forwarded to a collection agency.
10. We require 24-hour notice for canceling any appointments. There is a **$25** charge for weekday appointments and **$45** charge for Saturday appointments if they are not canceled OR if 24-hour notice is not given.
11. A **$35** fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.
12. Not all services provided by our office are covered by every plan. Any service determined to not be covered by your plan will be your responsibility.

I have read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name _____

Date _____