PAYING AT THE TIME OF SERVICE POLICY

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. We are able to do this because paying at time of service frees this office from time-consuming paperwork, verifying insurance, obtaining pre-authorization and tracking of filed insurance claims.

At your initial visit, you will be responsible for the new patient office visit, after which time you will be responsible for a standard office visit. However, there are several procedures that may occur during your visits, which will be reflected on your explanation of benefits letter from your insurance. Any of these procedures used during your treatment may be reduced to $0.00 at our discretion, and you will be responsible for the office visit fee only.

97810 Acupuncture (First15 min)	97811 Acupuncture (Additional 15 min)
97140 Manual Therapy	97530 Kinetic Activities
97110 Therapeutic Exercises	97026 Infrared

Patient responsibility is usually between $110.00 and $150.00.

PRIVACY POLICY

Privacy Policy – All records are kept strictly confidential and are subject to HIPAA compliance and will not be shared with any outside establishment, individual, organization or medical facilities without explicit **written** consent from the client (you) or the client's legal guardian. Unless legally required by local, state, or federal subpoena, summons or other court order. A copy of our Privacy Policy/ HIPPA rights has been provided and/or made available to me.

I have read the above three (3) policies and understand my rights and agree to abide by said policies.

_____	_____	_____
Printed Name	Signature	Date

Financial Responsibility / Assignment of Benefits/Patient Consent Form

I hereby authorize Patricia Seykora, acupuncture physician (hereinafter "Provider) to furnish Acupuncture, Massage, Acupoint Injection Therapy. Moxibustion, Gua Sha, Cupping Therapy and/or various other therapeutic treatments and any other therapies within the practitioner's scope of practice.

I authorize Provider to release any medical or other information that may be necessary to process medical claims on my behalf to related physicians, rehabilitation counselors, social workers, insurance carriers, or attorneys. I authorize Provider to initiate a complaint to the Insurance Commissioner for any reason on my behalf should the provider feel there is a valid reason for doing so.

I understand that I am responsible for paying my co-payments, co-insurance and deductibles at the time of service. I also understand that I am responsible for any balance due after payment by my insurance company. I understand that my insurance company may not cover my all or part of my visit and treatment. Should they not cover it, I understand that the money I have paid is only an estimate of the amount that my insurance company may say I owe, and that the Provider must bill me for the amount due, per my insurance company. I also understand that should my insurance allow and pay for the acupuncture treatment and decide I owe less than what I have paid the provider, that the provider will refund me the difference between what I paid and what the insurance company says I owe. I also understand that because the Provider may be out of network I agree not to request a refund from the provider should the insurance company pays all or part of my visit and subsequent treatment; unless the insurance company indicates that I am due a refund. I also agree that should my insurance company send a check to me, I agree to immediately turn those funds over to the Provider.

I, the undersigned, understand that Provider will bill my insurance carrier for services rendered. I understand that verification of benefits is not a guarantee of payment and my financial responsibility is subject to change. If my insurance company fails to render payment for services rendered, I hereby personally guarantee payment for medical care and services rendered. If my insurance company does not remit payment within 60 days, I understand that I will be responsible for the balance due in full.

I hereby request that my insurance carrier make payment directly to the Patricia Seykora, AP, for all services rendered by this facility. If my current policy prohibits direct payment to Provider, I hereby instruct and direct my insurance carrier to make the check out in my name but send the check to Provider.

If my insurance carrier makes payments to me I agree to immediately pay over these funds to Provider. I also authorize Provider, to deposit any check(s) received on my account when made out to me and bearing my endorsement.

I understand and agree that if I fail to make any of the payments or turn over funds paid to me by my insurance for which I am responsible in a timely manner, I will be held responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

Charges related to Workers Compensation injury shall be forwarded to the Workers Compensation Insurance carrier and I will not be held personally responsible for these charges. I understand that if I claim Worker's Compensation benefits and those benefits and are subsequently denied, I may be held responsible for the total amount of charges for services rendered.

Benefits Provider receives from my insurance carrier at the time of service are not a guarantee of benefits. I understand and acknowledge that as the patient, legal guardian or parent (if the patient is under 18 years old) I will be responsible for the co-payment and the deductible at the time of service.

_____ _____

Patient/Guardian Date

_____ _____

Witness Date

NO SHOW/ CANCELLATION POLICY

Patricia Seykora, AP currently has up to a two-week waiting list for acupuncture appointments. Due to the high demand for appointment and the limited availability, we are strictly enforcing our late-cancellation and no-show policies.

Please be advised that failure to show for your scheduled appointment will result in you being charged the full amount of your scheduled treatment. Cancellations for appointments must be at least twenty-four (24) hours prior to your scheduled appointment or you may be charged your scheduled treatment fee. Please arrive 10-15 minutes prior to your scheduled appointment. We understand that life often puts unplanned obstacles in our path and any fee assessments will be determined on a case-by-case basis. You can minimize the potential for fees by calling us if you are running late or cannot make your appointment.

Please keep in mind that a single late arrival can cause our providers to run behind schedule the entire day, thereby increasing the amount of time patients must wait to be seen. We strive to keep wait times to a minimum and may require you to reschedule your appointment should you arrive more than ten (10) minutes late. Patients arriving 15 minutes or more, late for their schedule appointment may be charged a no-show fee.

We do have a waiting list and are working to get everyone in as quickly as possible.

_____ _____

Patient/Guardian Date

_____ _____

Witness Date