# Golden Root Acupuncture

## OFFICE POLICIES

**Cancellations and missed appointments.** Please provide 24-hour notice of cancellation prior to your scheduled appointment. Patients who do not attend a scheduled appointment will be responsible for a no show fee in the amount of your scheduled appointment. Patients who do not provide 24-hour notice will be responsible for a late cancellation fee of $50. This charge must be paid in full on or before your next scheduled appointment.

**Reasons for being dismissed/denied treatment.** Patients who show inappropriate conduct, non-or-late payment of fees, or safety concerns may be denied treatment.

## FINANCIAL POLICY

Your payment is due in full at the time of service. We accept cash, check or credit cards (VISA, MasterCard, American Express, Discover). For checks returned unpaid by your bank, you will be charged a $25 fee.

## INSURANCE POLICY

If you have insurance that covers acupuncture and have in-network benefits, we will submit claims for you. If you are insured by a company outside of our network and wish to request reimbursement for your treatment, we will provide you with a superbill upon your request. You are responsible for your deductible, co-payment, and any non-covered services.

We do our best to predict the amount your insurance company will cover. However, the exact amount is unclear until we receive the explanation of benefits (EOB) from your insurance company. If in the event you were charged a different amount than what your insurance company determines is your responsibly, you will either be reimbursed or charged the difference.

## RECORDS RELEASE & ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorized the release of any information to claims for benefits submitted. I further agree and authorize Golden Root Acupuncture to submit claims for benefits, for services rendered, without obtaining my signature on each claim. I understand that I am financially responsible for all charges incurred, whether or not they are covered by my insurance company. This authorization shall remain valid until written notice is given by me revoking said authorization.

**Please indicate your understanding and acceptance of these polices by signing below.**

| _____ | _____ | _____ |
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| Patient Signature | Patient's Name | Date |