INSURANCE VERIFICATION/FINANCIAL AGREEMENT

To complete this form, please call your insurance carrier prior to your appointment and ask the questions below so that you are aware to the furthest extent possible of your benefit levels. Please bring this form to your appointment with you.

Disclaimer: I understand that even if my insurance company tells me that my insurance covers acupuncture, my unique plan might cover only specific medical conditions, that there might be other limitations to my benefits, and that the representative might not give me accurate or complete information. I understand that the information my insurance company gives me is out of the control of Wisdom Ways Acupuncture, and I agree to not hold Wisdom Ways Acupuncture responsible for any information that was inaccurately or incompletely provided to me by my insurance company. Please initial _____

Patient Name _____ Date of Birth _____

Insurance Company Name _____ Insurance Phone _____

ID # _____ Group # _____

Policyholder Name_____Relationship_____Date of Birth_____

Call date _____ Rep Name: _____Call reference # _____ Acupuncture coverage: Yes ☐ No ☐

To verify participating provider status provide Tax ID# 900810238

Do I have a: Copay ?_____ Co-insurance % ?_____ Deductible ?_____ Is it met? Yes ☐ No ☐

visits per year? _____ How many used? _____ Combined with other services such as PT or Chiro? _____ (specify)

Pre-authorization or referrals required? Yes ☐ No☐ Referring provider_____ Phone_____

Is there a dollar amount limit? Is so, how much? _____

I understand that Wisdom Ways Acupuncture will file to my insurance carrier on my behalf, and by signing below I authorize my insurer to pay any benefits directly to Wisdom Ways Acupuncture. I know that I am responsible for any deductible and copay/coinsurance amounts as determined by my contract with my insurance carrier. I also understand that by completing and signing this form, this is not a guarantee of payment by my insurer for any of the above procedures; and that by billing my insurer, Wisdom Ways Acupuncture is in no way taking responsibility for guarantee of payment by my insurance company. **I am responsible for any balances unpaid by my insurer.**

If I do not have health insurance, I am responsible for all services rendered and agree to pay in full at the time of service.

I have read and agree to the above:

Patient Name _____ Signature _____ Date _____

Self- Pay and Package Purchase Agreement

I understand that should I choose to use insurance in the future, I will be in a contracted rate that will vary depending on my insurance plan and treatment received; and that I am contractually bound to those rates. Therefore, I understand that since I am purchasing treatment at a discounted package rate and/or self-pay rate, the treatments in this package will not be able to be billed towards insurance. Any treatments I receive after this treatment package runs out can be billed towards insurance. **Package refunds:** All treatments will revert to the individual treatment rate, and the remaining unused balance will be refunded.

_____ _____

Patient Signature Date