Acupuncture NYC 303 5th Ave, Suite 1501 New York, NY 10016 ayacupuncture@gmail.com

FINANCIAL AGREEMENT

As a courtesy we bill your insurance carrier. However, it must be understood that the contract is between you and your insurance carrier and you are fully responsible for any amount that they do not pay.
Co-pay or co-insurance is due at the time of service. Any optional therapies chosen by you and not covered by insurance are also due at time of service. Some insurance plans do not cover acupuncture. If your plan denies coverage, you are responsible for the full amount of your bill. Any payments received from your insurance company for your acupuncture treatments have to be forwarded to our office within 3 business days. If your insurance requires a referral from your primary care physician for treatment, you will be responsible for payment of all services until our office has received a hard copy of the referral. If at a later date your insurance reimburses for services that you paid for at the time of the visit, that amount will be refunded to you.

Failure to provide us with adequate information regarding your insurance may result in a denial from your insurance carrier and you will be responsible for any unpaid balance. Please make sure that we have all the necessary information to process your claim.

3% service charge will be applied to any unpaid balanced past 30 days. Unpaid balance past 90 days will be forwarded to collection agency. A copy of our fee schedule is available upon request.

ASSIGNMENT AND RELEASE

I hereby authorize my benefits to be paid directly to Andrey Yershov Acupuncture NYC. I am financially responsible for any balance due. I also authorize the practitioner(s) listed to release any information required for this claim.

I authorize the release of any medical or other information necessary to the process of this claim. I also authorize payment of government benefits either to myself or to the party who accepts assignment in Box 27 of the CMS 1500 form on which claims for me are submitted.

BY SIGNING BELOW, YOU ARE ACKNOWLEDGING YOUR UNDERSTANDING OF THE FINANCIAL POLICIES DESCRIBED ABOVE.

I HAVE READ AND UNDERSTAND THESE POLICIES AND MY RESPONSIBILITY CONCERNING THE PAYMENT OF THESE SERVICES.

Patient/Guardian Name ____

Signature____ Date______________________________