Chuck Graham Acupuncture

FINANCIAL POLICY AND AUTHORIZATION TO BILL INSURANCE

There are two billing options available for you. Please select the one you prefer me to use for your visits. If at any time you choose to change your billing option, you are required to let me know immediately and sign a new Office Financial Policy and Authorization to Bill Insurance Form.

_____ Private Pay

Private Pay patients are patients that do not bill insurance. This discounted cash rate is only applied to the published rate if you pay at the time of service.

______ Insurance Billing (Medical or Auto Insurance)

I understand that I must pay all co-payments and/or co-insurances not covered by my insurance company at the time of check in for today's visit, and every visit hereafter. Chuck Graham Acupuncture will submit my claim for me to my insurance company. Although Chuck Graham Acupuncture verifies my insurance; **I understand that this verification is not a guarantee of payment.** I understand that any and all charges incurred at this office including co-payment, co-insurance, percentage due and/or deductibles or any other fees or services not covered by my insurance company are **my responsibility. I understand that if these patient portions due are not paid at the time of service I will be subject to a $10.00 billing fee per month – no exceptions until the outstanding amounts are paid.** I further understand that any unpaid balance **over 90 days**, can and will be sent to collections for recovery unless prior arrangements have been made.

I authorize my insurance benefits to be paid directly to Chuck Graham Acupuncture. I also authorize the provider to release any information and medical records required by my insurance company. I understand that I may revoke this consent by written request, at any time. No other records shall be released without my signed consent.

____ Date __________
Signature of Responsible Party

____ Date __________
Signature of Person Authorized to Consent