ACUBLISS
ACUPUNCTURE & HOLISTIC MEDICINE

OFFICE POLICIES

Cancellations & missed appointments: Please provide 48-hour notice of cancellation prior to your scheduled appointment. If you miss an appointment or cancel within 48 hours you will be charged the appointment fee.

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. For your convenience, we accept cash, check or credit cards (Visa or MasterCard only). For checks returned to us as unpaid by your bank, you will be charged a $25 fee.

INSURANCE POLICY

Many Insurance companies cover acupuncture! We are happy to verify coverage and check benefits for you. If you have insurance that covers acupuncture we will submit your claims for you. You are responsible for your deductible, co-payment, and any non-covered or excluded amounts under your policy. If your insurance denies payment of a claim you are responsible for billed charges. In the case that your insurance company sends a check directly to you for the payment of the treatment, you hereby agree to endorse the check to **AcuBliss** and turn over payment with accompanying Explanation of Benefits form. If your insurance company does not cover acupuncture or if I am not an approved provider for your insurance, I will gladly give you a receipt for all of your treatments so you can submit them to your insurance company for reimbursement.

Procedure Code	Description of Services	Billed Charge
99203	New Patient Evaluation	$145
97810	Acupuncture, first 15 minutes	$90
97811	Acupuncture, additional time	$55
97014	Electric Stimulation	$20
97016	Cupping Therapy	$25

RECORDS RELEASE & ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information to claims for benefits submitted. I further agree and authorize Amorette LaFranchi L.Ac. 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 policies by signing below.

_____ _____ _____

Patient's Signature Patient's Name Date

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