ACUPUNCTURE & WELLNESS CENTER

# Office Policies

**Cancellation**

Acupuncture & Wellness Center strives to provide the most professional care for our patients. In doing so we provide a structure in our treatment schedules that enable us to ensure the best care for all we serve. We ask that you provide us with at least 24-hour notice if for some reason you must cancel your appointment. No shows or frequent cancellations will mean that a slot that could have gone to another patient would be unfilled. Therefore, under these circumstances, we will charge a $40 missed appointment fee. Thank you for your understanding.

**Tardiness**

As we make every effort to see you on time, we must ask that you call our office if you anticipate being late for an appointment. We understand that occasionally delays will lead to arriving late to an appointment. Appointment times are as scheduled and cannot extend beyond the stated time to accommodate late arrivals. Please arrive 5 minutes prior to your scheduled visit so that your treatment can begin on time. You will still be responsible for full payment.

For patients showing up later than 10 minutes, we will have to reschedule your visit so that we can be punctual to our next appointment. You will be responsible for the missed appointment fee.

**Sickness**

If you or members of your household are experiencing signs of illness, please call the office as soon as possible to reschedule your appointment. You will not be permitted to enter the facility. Symptoms include sudden loss of taste or smell, fatigue and/or weakness, shortness of breath, cough, sore throat, runny nose, fever.

**For Patients Billing Insurance:**

**Cancellation**

We do not bill insurance companies for missed appointments or late cancellations (less than 24-hour notice). You are responsible for paying the missed appointment/late cancellation fees.

**Veteran Cancellation**

For Veterans authorized by the VA, we cannot bill or collect payment for missed appointments or late cancellations. Frequent no-shows, tardiness, or late cancellations will result in discharge from treatment.

**Financial Responsibility**

Once your insurance is verified, we will bill and accept payment from your insurance company for covered services. In the event that the insurance company denies payment or makes partial payment, you are responsible for the balance, deductibles, and co-pays. Your signature below confirms your financial responsibility for all services regardless of insurance reimbursement.

**Assignment Benefits**

Your signature below authorizes and directs payment of medical benefits to the acupuncture practitioner for services provided by this office.

**Release of Medical Records**

Your signature authorizes the release of your medical records on file in this office, for the purpose of processing your claims to the following: your attorney, the health care providers attending to this condition, and the insurance case managers. Medical records will not be edited unless otherwise stated in an exclusive release of medical records signed through your attorney.

Print Patient Name:_____

Signature of Patient:_____ Date:_____

ACUPUNCTURE & WELLNESS CENTER

I, _____ (Print Client Name) agree to the terms outlined in these office policies, and I hereby authorize Acupuncture & Wellness Center to charge $40.00 in the event of a missed appointment.

**Client Signature** _____ **Date** _____

*We ask that you keep your credit card information on file current. Please call and/or bring updated credit card information with you if your current card is going to expire.*

Credit Card Number _____ Expiration Date _____

Name as it appears on card_____

Security Code_____ (CVV2,AMEX) Billing zip code _____

Signature _____