



## Acupuncture Savvy

### Financial Policy

I understand that all treatments received from Teresa Savarino, Lac, are my financial responsibility and I agree to pay for all treatments at the time of service unless other arrangements have been made in writing. We accept: cash, check, debit and credit card.

**Insurance:** If your health or personal injury (PIP) insurance offers acupuncture benefits, we will bill your insurance directly as a service to you.

If we have a contract with your insurance, we are legally obligated to accept their allowed amount on your behalf. We also must collect your co-pay at that time of service.

If you have a personal injury (PIP) claim, we will bill your insurance company. If the insurance does not cover 100% of the bill, you will be responsible for the difference.

We will make every effort to verify benefits for you. However, insurance coverage is a contract between you and your insurance company. Information from insurance companies is not a guarantee of benefits. You agree to be responsible for any amount that your insurance plan does not cover.

**Cancellation Policy:** We require twenty-four (24) hours notice when cancelling an appointment. You also understand that you will be directly charged (insurance does not cover missed appointments) for missed appointments that are not canceled according to the twenty-four hour policy, and agree to pay for as such. Charges are \$50 for a missed appointment.

Please initial each item below:

- \_\_\_\_\_ I authorize the provider at Acupuncture Savvy to provide healthcare services to me.
- \_\_\_\_\_ I understand and agree that regardless of insurance coverage, I am liable for any charges incurred as a result of services rendered to me by the provider of Acupuncture Savvy.
- \_\_\_\_\_ If my account is assigned to an attorney for collection and/or suit due to delinquency, the prevailing party shall be entitled to Attorney's fees and cost for collection.
- \_\_\_\_\_ I authorize any insurer to make payment for services rendered by Acupuncture Savvy, directly to Acupuncture Savvy, at 4500 9<sup>th</sup> Avenue NE Seattle, WA 98105.
- \_\_\_\_\_ I authorize the release of records to third parties requiring records for determination of financial liability.

I have read and fully understand the above statements. All questions regarding the practitioner's objectives pertaining to my care in this office have been answered to my satisfaction. I there accept care on this basis.

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_