M.S. Acupuncture Clinic

697 Mobil Ave. Camarillo, CA93010 / Phone: 805- 484-9013 Fax: 805- 484- 9015

FINANCIAL RESPONSIBILITY/ ASSIGNMENT OF BENEFITS

Thank you for choosing M.S. Acupuncture clinic as your healthcare provider. We are honored by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

CANCELLATION POLICY: We require 24 hours' notice if you are unable to keep your appointment.
Missed Appointment FEE: $60.00

CASH PATIENTS:
For those patients who do not have insurance, or have an insurance policy that does not cover acupuncture services, payment is expected at the time of service. For your convenience, we accept personal checks, Visa, Mastercard, and Discover.

We gladly accept most insurance; but **Dr. Kim DOES NOT participate with any managed care programs such as PPO or HMO plans.** Many of these insurances do provide out of network benefits. If your plan provides out-of-network benefits, as a courtesy, we will bill your insurance carrier on your behalf. Please take the time to become familiar with your benefits, particularly your deductible and co-pay responsibilities and additional stipulations that may affect your coverage. It is the responsibility of the patient to ensure that the insurance information on file is current. Any changes must be brought to the attention of the clinic as soon as possible to ensure accurate billing. Most insurance companies require you pay **co-pays and/or deductibles which are due at the time of service**. If your insurance carrier denies any part of your claim or has not paid within 90 days of billing, professional fees are due and payable in full from you. If payment responsibility is not met in a timely fashion, we will send your account directly to collections. **Patients may incur and are responsible for the payment of additional charges including, but not limited to, generation of statements, returned checks, copies and distribution of medical records, and costs associated with the collection of patient balances.**

I authorize M.S. Acupuncture Clinic to bill my insurance company.

I understand that I am responsible for paying my co-payments, co-insurance and deductibles at the time of service.

I also understand that I am responsible for any balance due after payment or non-payment by my insurance company.

I hereby request that my insurance carrier make payment directly to MS Acupuncture clinic for all services rendered by this facility.

In the case that my insurance company sends a check directly to me for the payment of the treatment, I hereby agree to endorse the check to MS Acupuncture clinic and turn over the payment with the accompanying Explanation of Benefits form.

_____ I do not have health insurance and will be responsible for services rendered by Provider.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.
I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form:

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Signature of Patient or Guardian Date