

Golden Acupuncturist,™

156 William St Suite 800 NY NY 10038

FINANCIAL ARRANGEMENTS

We realize that every person’s financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the health care needed to enjoy a healthy and pain-free lifestyle with respect to your budget.

MEDICAL INSURANCE

We are happy to file the forms necessary to see that you receive the full benefits of your coverage; however, we can make no guarantee of any estimated coverage. Because the insurance policy is an agreement between you and the insurance company, we ask that all patients be directly responsible for all charges. Please know that we will do everything possible to see that you receive the full benefits of your policy. If for some reason your insurance company does not pay estimated benefits, then you are responsible for the entire treatment fee.

PAYMENT OPTIONS

The patient co-payment and deductible are due at the time of service. For your convenience, the following payment options are available:

- 1. Cash or Check We are happy to accept payment by cash or check.
- 2. Credit Cards For your convenience we have made arrangements to accept payment by MasterCard, VISA and certain debit cards.
- 3. Insurance Filing Option For those who prefer that we file your insurance claims: if your insurer has not made payment on your claim within 45 days, your balance will be transferred to your bank credit card account. When the insurer remits payment, we will refund that amount to your card.

TREATMENT ESTIMATOR:

Estimated Insurance Coverage:

Deductible	_____	
General Copay	_____	
Percentage Covered	_____	
Patient Copay Portion	_____	
Credit Card Number	_____	Exp._____ Sec._____

My signature below acknowledges that I understand that I am responsible for the entire treatment fee. Please note: to provide you with optimal care we reserve your appointment time and require 24 hours’ notice when canceling or rescheduling your appointment. You will be charged the full price of your reserved appointment if you have not provided the required notice.

Date

Patient Signature

Print Name