Office Policies

Welcome to Soli Acupuncture and Natural Medicine. We want you to be comfortable and receive the best care possible. Please do not hesitate to ask any questions you might have regarding your visit, your billing, or our policies.

FEES The fees charged in this office are comparable to those charged by other healthcare providers in this area, with similar qualifications. Please ask to see or review our fee schedule. We accept cash, credit cards, and personal checks. Please note that there is a $25.00 charge for checks returned due to insufficient funds.

Initial_____

INSURANCE COVERAGE Many insurance companies do cover Acupuncture, but we do not claim that yours does. Policies can vary greatly in terms of deductible and percentage of coverage for Acupuncture. We can verify coverage and submit your claim form for reimbursement, provided you sign financial agreement down below.

Initial_____

RELEASE OF INFORMATION Your insurance company may require medical records to document our treatment and progress. Your initials down below authorize the release of medical information necessary to process your claim.

Initial_____

CANCELLATIONS As a courtesy to our office and our patients, we ask that you please notify the office at least 24 hours in advance if you need to cancel or reschedule your appointment. You will be charged a $25.00 fee for any missed appointment or cancellation giving less than 24-hour notice for any non-emergency situation.

Initial_____

FINANCIAL AGREEMENT/ASSIGNMENT OF BENEFITS

I, (print full name) _____, am receiving or about to receive health care services in this office. I understand that I am responsible to pay all non-insurance related fees when services are rendered, including herbs, etc. If I choose to use my insurance I understand I will be responsible for all “non-covered” services and/or coinsurance/co-pays associated with my office visit. In addition, I authorize insurance payment of medical benefits to Soli Acupuncture & Natural medicine.

By signing below, I agree to comply with the office policies stated above which I have read and understand. I also authorize the use of this signature on all insurance submissions.

_____ _____

Patient Signature Date