OFFICE POLICIES OF

ACUPUNCTURE OF MORRIS COUNTY

Welcome to the office of ***Acupuncture of Morris County***. We want you to be comfortable and to receive the best care possible. Please do not hesitate to ask any questions you might have regarding your visit, your billing, or our office 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 our fee schedule. We accept cash, personal checks and VISA, MasterCard and Discover. Please note there is a $25.00 charge for checks returned due to insufficient funds. Initial_____

INSURANCE COVERAGE. Many insurance policies cover Acupuncture, but we do not claim that yours does. Policies can differ 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 the financial agreement below. Initial_____

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

TARDINESS. Everyone is happier when everyone is on time. We will make our best effort to be on schedule for you. In order to do that, we request that you are on time for your appointments. Because New Jersey traffic can be a major obstacle to timeliness, please take that into consideration and try to arrive 5-10 minutes early. If you are going to be more than 15 minutes late, please call our office to let us know. We will do our best to accommodate you if there are any available appointments later in the schedule. If you are less than 15 minutes late, your consultation and treatment time may of necessity be shortened. Please understand that our intent with this policy is to help us to provide timely and effective treatments for you and all of our patients. Initial_____

CANCELLATIONS. As a courtesy to our office and other 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 hours notice for any non-emergency situations. 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. 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 ***Acupuncture of Morris County***.

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

Signed_____ Date_____