Saharnaz Rezania, Acupuncturist LLC

OFFICE POLICIES

FEES: Our practice is committed to providing the best treatment possible for our patients. We charge what is usual and customary for our area. Please be aware that some and at times perhaps all of the services may be non-covered services and not considered reasonable and necessary by medical insurance. All payments are due at the time of service. We accept cash, credit cards, and personal checks. Please note there is a $25.00 charge for checks returned due to insufficient funds.

Initial_____

CANCELLATION POLICY: Please contact us at least 24 hours before your scheduled appointment to cancel or reschedule. We enforce a strict cancellation policy and you will be charged the full amount for your scheduled appointment time if cancellation or rescheduling is less than 24 hours before your appointment.

Initial_____

INSURANCE COVERAGE: Although many insurance policies cover Acupuncture, 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. You will be responsible for any applicable deductions and copayments. Copayments must be paid at the time services are rendered. If you're not eligible at the time services are rendered, you're responsible for full payment.

Initial_____

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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 Saharnaz Rezania, Acupuncturist LLC.

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.

Signature _____ Date _____

Name _____