

**Bergen Acupuncture and Integrative Medicine, LLC**  
**Financial Agreement**

We would like to take a moment to welcome you to our office and assure you that you will receive the very best of care available for your condition. In order to familiarize you with the financial policy of this office we would like to explain how your medical bills will be handled.

**Explanation of Insurance Coverage:**

Many insurance policies do cover acupuncture care but this office makes no representation that yours does. Insurance policies may vary greatly in terms of deductible and percentage of coverage for acupuncture care. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balances in this office. We will do our best to verify your insurance coverage, and will bill your insurance in a timely manner.

**Payment Arrangements:**

We require that you pay **\$20.00** towards today's and future charges, unless otherwise specified by your insurance carrier. Your full obligation and portion of the bills is expected to be when the payment is received from your insurance carrier. Any unpaid balances will be considered past due 30 days following insurance reimbursement. Past due balances may have an interest charge of 1.5% applied per month.

**Assignment of Benefits:**

This form directs your insurance company to send payments directly to this office. If your insurance carrier sends payment to you for services incurred in this office, you agree to send or bring those payments to this office upon receipt.

**Release of Information:**

If your insurance company requires medical reports to document your treatment or progress, your signature below authorizes this office to release the medical information necessary to process your claims.

**Voluntary Termination of Care:**

If you suspend or terminate your care at any time, your portion of all charges for professional services is immediately due and payable to this office. All services rendered by this office are charged directly to you, and you, ultimately will be personally responsible for payment regardless of your insurance coverage.

**Appointment Cancellation:**

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel within that time or do not show up, I may be charged **\$40.00** for that appointment session.

We hope this answers any questions you might have concerning the financial policy of this office. Once again we welcome you to our office, and will be glad to answer any further questions that you might have.

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I have read and agree to the above.

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Signature

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Date