Chao-Lung Liu, AP / Pei-Lu B Chang, AP

FINANCIAL POLICY

Financial policy contract between **Chao-Lung Liu, AP / Pei-Lu B Chang, AP** herein after referred to as "PROVIDER" and PATIENT NAME _____, herein after referred to as "PATIENT", for services provided at BA NATURAL BODY CARE, herein after referred to as "FACILITY".

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment. All patients must complete our Patient Information sheet before seeing the doctor.
FULL PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, MASTERCARD, VISA, AMEX AND DISCOVER.

Regarding Insurance
We will verify coverage prior to treatment. If for any reason we are not able to verify coverage prior to your treatment, the PATIENT will be charged for each treatment until verification is obtained. PROVIDER's fees are determined by the complexity of the particular case and the different services used during treatment. Any balance due on PATIENT's treatments is PATIENT's responsibility whether PATIENT's insurance company pays or not. PROVIDER cannot bill your insurance company unless PATIENT brings in all insurance information. PATIENT's insurance policy is a contract between PATIENT and PATIENT's insurance company. PROVIDER is not party to that contract. In the event PROVIDER does not accept assignment of benefits, PROVIDER requires that PATIENT provide a credit card number with authorization to bill that account for any balance PATIENT's insurance company does not pay. If PATIENT's insurance company has not paid PATIENT's account in full within 60 days, the balance of PATIENT's account will be automatically transferred to PATIENT's credit card. If PATIENT receives a check from their insurance company for services provided by this PROVIDER, PATIENT will sign over that check in full immediately and give to PROVIDER.
When billing for a new insurance patient, it is the policy of this PROVIDER to charge the appropriate office visit fee, (Patient's Paying at Time of Service' price). Until PROVIDER actually receives payment from the insurance company, there is no guarantee of payment from the insurance company, (no matter what we were told / thus the 'Benefits Disclaimer' form).

Assignment of Benefits:
This AGREEMENT is made and entered into by and between the PATIENT and PROVIDER. Whereas, PATIENT desires to receive services from this PROVIDER and therefore desires to assign certain rights and benefits to PROVIDER, it is hereby agreed that I, the PATIENT, assign to my Health Care PROVIDER, all money to which I am entitled for medically related expenses received at or through the above mentioned facility. If PATIENT receives a check from their insurance company for services provided by this PROVIDER, PATIENT will sign over that check in full immediately and give to PROVIDER.

Usual and Customary Rates (UCR)
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 provided may be "non-covered" services and not considered reasonable and necessary under the Medicare program and/or by other medical insurance. You are responsible for payment in full regardless of any insurance company's arbitrary determination of usual and customary rates.

Cancellations
Please be kindly to call and cancel appointments 12-24 hours in advance. If patient fail to call our office in advance to cancel, our policy is to charge $25 for missed appointments from the patients. Your treatments will be more effective if you follow your doctor's guidelines and stick to your treatment schedule. Please help us to serve you better by keeping scheduled appointments.

In signing this document, you are assigning benefits to the provider(s)/office listed at the top of this page, to which you are eligible to receive for care rendered by this provider(s)/office. Additionally, in signing this document, you authorize the release of any information to any insurance company, adjustor, insurance biller, or attorney that will assist in the payment of a claim.

Thank you for understanding our financial Policy. Please let us know if you have any questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy. A photocopy of this form shall be considered as effective as the original.

_____
Print Name

_____DATE_____
Signature of Patient or Responsible Party