**INSURANCE VERIFICATION/FINANCIAL AGREEMENT**

***To complete this form, please call your insurance carrier prior to your appointment and ask the questions below so that you are aware to the furthest extent possible of your benefit levels. Please bring this form to your appointment with you.***

**Disclaimer:** I understand that even if my insurance company tells me that my insurance covers acupuncture, my unique plan might cover only specific medical conditions, that there might be other limitations to my benefits, and that the representative might not give me accurate or complete information. I understand that the information my insurance company gives me is out of the control of Wisdom Ways Acupuncture, and I agree to not hold Wisdom Ways Acupuncture responsible for any information that was inaccurately or incompletely provided to me by my insurance company. Please initial \_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policyholder Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Call date \_\_\_\_\_\_\_\_\_ Rep Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Call reference # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Acupuncture coverage: Yes No

**To verify participating provider status provide Tax ID# 900810238**

Do I have a: Copay ?\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Co-insurance % ?\_\_\_\_\_\_\_\_\_\_\_\_ Deductible ?\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is it met? Yes No

# visits per year? \_\_\_\_\_\_\_ How many used? \_\_\_\_\_\_\_ Combined with other services such as PT or Chiro? \_\_\_\_\_\_\_\_\_\_\_\_\_ (specify)

Pre-authorization or referrals required? Yes No Referring provider\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there a dollar amount limit? Is so, how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that Wisdom Ways Acupuncture will file to my insurance carrier on my behalf, and by signing below I authorize my insurer to pay any benefits directly to Wisdom Ways Acupuncture. I know that I am responsible for any deductible and copay/coinsurance amounts as determined by my contract with my insurance carrier. I also understand that by completing and signing this form, this is not a guarantee of payment by my insurer for any of the above procedures; and that by billing my insurer, Wisdom Ways Acupuncture is in no way taking responsibility for guarantee of payment by my insurance company. **I am responsible for any balances unpaid by my insurer.**

If I do not have health insurance, I am responsible for all services rendered and agree to pay in full at the time of service.

I have read and agree to the above:

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_

**Self- Pay and Package Purchase Agreement**

I understand that should I choose to use insurance in the future, I will be in a contracted rate that will vary depending on my insurance plan and treatment received; and that I am contractually bound to those rates. Therefore, I understand that since I am purchasing treatment at a discounted package rate and/or self-pay rate, the treatments in this package will not be able to be billed towards insurance. Any treatments I receive after this treatment package runs out can be billed towards insurance. **Package refunds:** All treatments will revert to the individual treatment rate, and the remaining unused balance will be refunded.

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Patient Signature Date