**INSURANCE VERIFICATION/FINANCIAL AGREEMENT**

Please call your insurance carrier prior to your appointment and ask the questions below so that you are aware of your benefit levels. Please bring this form to your appointment with you.

***You are ultimately responsible for ensuring coverage before receiving treatment, so please take the time to thoroughly understand your benefit and plan limitations so you will not be left with unexpected charges.***

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

Insurance Company Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Claims Mailing Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_

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

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

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

In network benefits: Copay \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Co-insurance % \_\_\_\_\_\_\_\_\_\_\_\_ Deductible \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Met? Yes No

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

**Procedure codes** (specifically ask the representative if the codes below are covered under your plan if provided by an Acupuncturist).

**Office Visits Acupuncture Procedures Other Treatments**

99203, 99204 (new patient) 97810, 97811 97026 Infrared TDP Therapy Lamp

99213, 99214 (established patient) 97813, 97814 97039/97799 Cupping/Moxibustion/Gua sha

97140 Myofascial/Tuina/Acupressure

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

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.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date