



## Leigh Caldwell, Licensed Acupuncturist

### OFFICE POLICIES

Welcome to the Acupuncture office of Leigh Caldwell, Licensed Acupuncturist. We want you to be comfortable and to receive the best care possible. Please do not hesitate to ask any questions you might have regarding your visit, your billing, or our policies.

**FEES** The fees charged in this office are comparable to those charged by other healthcare providers in this area having similar qualifications. Please ask to see our fee schedule. We accept cash, credit cards, and personal checks. Please note there is a \$25.00 charge for checks returned due to insufficient funds.

Initial\_\_\_\_\_

**INSURANCE COVERAGE** Many insurance policies cover Acupuncture, but we do not claim that yours does. Policies can differ greatly in terms of deductibles and percentages of coverage for Acupuncture. We can verify coverage and submit your claim form for reimbursement, provided you sign the financial agreement below.

Initial\_\_\_\_\_

**RELEASE OF INFORMATION** Your insurance company may require medical reports to document our treatment and progress. Your initials below authorize the release of medical information necessary to process your claim.

Initial\_\_\_\_\_

**CANCELLATIONS** As a courtesy to our office and other patients, we ask that you please notify the office at least 24 hours in advance if you need to cancel or reschedule your appointment. You may be charged a \$25.00 fee for a missed appointment or cancellation with less than 24-hours' notice for a non-emergency situations.

Initial\_\_\_\_\_

### 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 Leigh Caldwell, L.Ac., 14101 Yorba Street, Suite 105, Tustin, CA 92780.

By signing below, I agree to comply with the office policies stated above which I have read and understand. I also authorize the use of this signature on all insurance submissions.

Signed\_\_\_\_\_ Date\_\_\_\_\_