Natalie Simak Acupuncture, LLC
NPI: 1902227
EIN: 45-3501929

5570 Sterrett Place, Suite 308
Columbia, MD, 21044
Tel: 443-474-4122

Please check your insurance policy to be sure of your acupuncture coverage, as I will have no access to your plan. I am on most of the BCBS plans, Aetna and United Healthcare, but please confirm that I am covered provider on your plan, how many treatments you are allowed per year, if there are any restrictions, such as "anesthesia only," and if you have met your out of pocket deductible for the year. If you have any other insurance plan, you will need to cover the cost of treatment and I can provide you with the detailed treatment receipt for possible reimbursement.

Patient Information	
Patient Name:	Date of Birth:
Street Address:	
City:	State: Zip:
Phone:	Email:
Emergency Contact Name:	Phone:
Primary Subscriber Insurance Information	
Insurance Company:	
Group/Plan Name:	
Policy ID #:	Group #:
Name of Primary Insured:	
Relationship to Patient:: Self Spouse Child Other:	
Call Insurance to find out the answers below related to acupuncture coverage	
Is Natalie Simak acupuncturist/provider: In Network Out Of Network	
Limits on acupuncture visits or treatments? Yes No What is the limit? _____ How many already used _____	
Any acupuncture related restrictions: anesthesia only pain only nausea only others:	
Is this a primary ___or secondary ____ insurance ? (check one – for secondary, please print and fill out another form)	
Is there a deductible ? Yes No How much: _____ How much met so far: _____	
Do acupuncture visits count towards meeting the deductible? Yes No	
What is your copay for acupuncture visits? _____	
Is there an out of pocket maximum? Yes No	

By signing below I agree that all of the information I have provided is true and I give permission to **Natalie Simak Acupuncture, LLC** to release medical records to my insurance company for the purpose of receiving payment. Under the circumstance that my insurance company does not pay for my scheduled office visits I will be responsible for payment directly to my acupuncturist at **Natalie Simak Acupuncture, LLC**.

_____ _____/____/_____

Signature Date

FINANCIAL AGREEMENT

We would like to take a moment to welcome you to our office ans 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 your 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 $_____ towards today's charges and $_____ on each visit. Your full portion of the bill is expected to be when 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. If you have a specific contracted amount for co-payment that amount is due on each visit.

I also agree that any check sent to me when I have not paid in full to the provider will be brought in to the provider to pay the remaining balance.

Assignment of Benefits

By signing this form you are authorizing payment of medical benefits will be made 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. However if you pay for your visits in full, the assignment will not be reported by this provider and any payment will be sent directly to you.

Release of Information

By signing this form you are also authorizing this office upon request from your insurance carrier the release of any medical or other information necessary to process the claim. You also acknowledge and request payment of government benefits either to myself or to the party who accepts assignment, namely this office.

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 the 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.

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

_____ _____/____/_____

Signature Date