

**PAYMENT FOR SERVICE**

The best care can be provided with open communication and mutual understanding. I, therefore, invite early discussion of financial concerns or questions regarding fees, payment from insurance carriers, etc.

**Patients are expected to pay at the time services are rendered.** **\*\*Initial here**\_\_\_\_\_. Because most PPO or Auto Insurance plans will cover your office visits I encourage you to let us verify your eligibility and benefits.

**INSURANCE:** Your insurance policy is a contract between you and your insurance company. It is important that you understand its provisions. **WE CANNOT GUARANTEE PAYMENT FOR YOUR CLAIMS.** If your insurance company pays only a portion of the bill, rejects your claim, or applies it toward your deductible you are responsible for the unpaid portion. When we receive payment or other information about your claims, an explanation of benefits will be sent to you, the policyholder. Please advise the office when you receive this information and let us know if you have any questions.

- Patients having PPO and Company benefits will be required to pay the normal co-payment, which typically ranges from \$5 to \$35.
- PATIENTS ARE REQUIRED TO REIMBURSE ALOHA ACUPUNCTURE, INC (DONNA KINI-BOWEN, AP) ANY AMOUNT PAID DIRECTLY TO THE PATIENT.

I hope that this information has been helpful in clarifying our payment policy.

**ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO PRIVATE, GROUP, ACCIDENT, AND HEALTH INSURANCE**

**PATIENT:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**INSURANCE COMPANY:** \_\_\_\_\_

**CLAIM/GROUP:** \_\_\_\_\_

**SS# OR ID#:** \_\_\_\_\_ **CUSTOMER SVC PH#:** \_\_\_\_\_

I hereby instruct and direct that the above Insurance Company pay by check made out and mailed to: ***Aloha Acupuncture, Inc., 89 Alafaya Woods Blvd., Oviedo, FL 32765.***

***Or:***

If my current policy prohibits direct payment to physician, then I hereby also instruct and direct you to make out the check to me and mail it as follows: ***Aloha Acupuncture, Inc., 89 Alafaya Woods Blvd., Oviedo, FL 32765.***

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. ***THIS IS A DIRECT ASSIGNMENT OF MY BENEFITS UNDER THIS POLICY.***

A photocopy of the Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

**Signature of Policyholder** \_\_\_\_\_ **Date:** \_\_\_\_\_

Office Signature \_\_\_\_\_