CORNERSTONE INTEGRATIVE MEDICINE

REGISTRATION & FINANCIAL AGREEMENT

NAME: DATE OF BIRTH: AGE

ADDRESS: DRIVER'S LICENSE

HOME#: MOBILE: EMAIL

EMERGENCY CONTACT

NAME RELATIONSHIP

HOME #: MOBILE #:

INSURANCE INFORMATION **Please present your insurance card to receptionist upon arrival or before appointment if requested**

PRIMARY INSURANCE NAME:

SECONDARY INSURANCE NAME:

INSURANCE AND FINANCIAL DISCLOSURES

Your insurance coverage is a contract between you and your insurance company. We will inform you if we are a party to your insurance contract, and will handle your claims according to our agreement with the insurance company. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, etc.

Verification of insurance coverage is your responsibility. If your insurance plan requires pre-authorization, it is the responsibility of you and your primary care provider to obtain pre-authorization for you to be seen by one of our providers. Otherwise, the charges incurred may become an out-of-pocket expense to you. When we are contracted with your insurance company we will bill them first as a courtesy to you. After explanation of benefit (EOB) and/or payment is received, the balance or remainder of balance is your responsibility. Final payment should be submitted in a timely manner (within 30 days from receipt of insurance payment/EOB or Date of Service).

AUTHORIZATION TO RELEASE BENEFITS, PAYMENTS AND/OR MEDICAL RECORDS

I request that payment of allowed and/or authorized benefits be made on my behalf to Cornerstone Integrative Medicine for any services provided. I also authorize Cornerstone Integrative Medicine to release any information from my medical record to the insurance company for payment of claim submitted.

PRIVACY PRACTICES ACKNOWLEDGEMENT (HIPPA)

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

RETURN CHECK FEE

In the event your check payment is returned by your financial institution, you will be responsible for the financial institution fee.

CANCELLATION AND/OR MISSED APPOINTMENT FEES

We require a 24 hour notice of appointment cancellations, otherwise a $ 50.00 late cancellation and / or missed appointment fee will be billed to you.

FORM FEES

Our fee schedule for ancillary & supplemental insurance forms is as follows: 1-2 pages $ 20.00; 3-5 pages $ 40.00; 6-10 pages $ 60.00; forms in excess of 10 pages $ 12.00 per additional page. California State Disability (EDD) forms $20.00; DMV Forms for disabled placard $ 20.00.

ACUPUNCTURE INSURANCE POLICY

Although we will help you keep track of your treatments, it is your responsibility to assure that you do not exceed the number of treatments allowed under your plan. You are accountable for any out-of-pocket expenses, such as deductible, co-insurance and co-pay and any non-covered service associated with each encounter.

If you wish to have more treatments than your insurance covers, or if your insurance does not cover acupuncture, we have a pre-service discount payment option which we recommend for cost savings. If your insurance covers acupuncture but we are not in their service network, we can provide an itemized statements for insurance reimbursement, although reimbursement might not be possible

Having read and understood this financial policy, I submit the following signature.

Name: Date:

If Signing on behalf of the patient, state name and relationship: