

## Billing Policy Agreement

The following sets forth the general billing policy for Acu-Choice Health Care.  
Please review this information and sign where indicated.

- Acu-Choice Health Care will bill any insurance that we have a contract with. I understand that it is my responsibility to know my insurance policy and the covered benefits within that policy. I understand that I am responsible for all co-pays, deductible amounts, and co insurance amounts, out of network amounts due as stated by your insurance plan. Please be aware that your insurance carrier can decide to drop/ discontinue coverage they provide to you for failure to pay these stated amounts. Your coverage is an agreement between you and your insurance carrier.
- If we do not have a contract with your insurance carrier we will be happy to provide you with a 'Super Bill'. This will enable you file a claim with your insurance carrier.
- I understand that it is my responsibility to provide the office of Acu-Choice Health Care with current, accurate billing information at the time of check in and to notify Acu-Choice Health Care of any changes in this information.
- I understand that it is my responsibility to know my specific co-pay (which can be different than my PCP co-payment). I further understand that this is a contractual agreement that I have with my health plan and that the clinic also has a contractual agreement with my health plan to collect co-pay amounts at the time of service.
- I understand that I will be billed for any amounts due by me (co-payments, co-insurance amounts, deductibles and any related out of network amounts) and that I have a financial responsibility to pay these amounts. I understand that I will be provided with statements for any balance due after insurance payment. I further understand that if I have

not made payment or payment arrangements and my account balance reaches 120 days past due, I may be sent to an outside collection service if I do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest or legal expenses with the collections efforts.

- I understand that I am responsible to obtain any prior authorizations required by my carrier prior to service rendered. I further understand that prior authorization is not a guarantee of payment and that I am responsible for any cost related to treatment received at Acu-Choice Health Care not paid by my insurance carrier.
- **Our office requires a 24- hour notice if you are unable to keep an appointment. Cancellations with out a 24- hour notice will be assessed a \$35.00 fee. This fee is not billable to your insurance carrier.**

My signature below confirms that I have read these billing policies and my financial obligation as pertains to the practitioners of Acu-Choice Health Care.

\_\_\_\_\_  
Guarantor/ Patient/ Responsible Party Signature

\_\_\_\_\_  
Date