A Better Way Massage and Acupuncture

My Financial Responsibility and Insurance Coverage

Patient (print): ________________________ Practitioner (print): ________________________________

My Primary Insurance coverage information for care was verified as follows:

Name of Health Plan: ____

Visit Limit # _________ Per ☐ Month/ ☐ Year

Dollar Limit $________ Per ☐ Month/ ☐ Year

Type of coverage and percentage of Co-insurance:

☐ HMO ☐ PPO ☐ Exclusive PPO ☐ Out of Network

_____________ % Health Plan Coverage

_____________ % Patient Responsibility

Deductible per year:	$ _______	of which $ _______	has been met
Out-of-pocket limit per year:	$ _______	of which $ _______	has been met
Co-Pay:	$_________	Per visit $ ______	Per Treatment

Prior Authorization or Referral *Required by Plan*?: ☐ Yes ☐ No *Was it Obtained*?: ☐ Yes ☐ No

Who at the Plan Office Approved or Authorized Care:

Coverage Verification

Health Plan Contact Person: Phone # Date & Time:

My Other Health Plan

Name of Insurer ____ Policy# __________________________

I know I am responsible for payment of any deductible, co-payment and coinsurance as determined by my health plan or program. I know you will collect these amounts at the time I get care. My insurance company may have additional requirements or limits that may affect my coverage like prior approval of care, visit limits, or other treatment limits. I agree to pay any amounts not covered by my health plan or program. If my plan does not cover any part of my care, or if I choose to continue care beyond the limits of my health plan, I will be completely responsible for payment of care.

I promise that the information I have provided is true and accurate to the best of my knowledge. I authorize my insurer or other benefit program to pay you directly for the services you provide. I agree to pay the full amount of all charges for care you provide me or the patient for whom I am financially responsible that remain after payment has been made by my insurer or other benefit program.

Signature: ____ Date: _______________________

Relationship to patient: ☐ Self ☐ Parent ☐ Guardian ☐ Other ____________________________

Missed Appointment Fee

I know you set aside time to provide me care; but, life can change suddenly and I might miss my appointment. If I don't give you at least 24-hours' notice in advance that I will miss my appointment, I will pay you $ 40 for the missed appointment which my plan or program will probably not cover and I will pay with my own money.

Signature: ____ Date: _______________________

Relationship to patient: ☐ Self ☐ Parent ☐ Guardian ☐ Other ____________________________

For Office Use Only

Date Received: ____________ File Reference #: ______________________________ Action: ______________________

Person Acting: ☐ Response/ Date: ☐ Filed Without Response