

INSURANCE INFORMATION AND CONSENT

*Kate Pagliasotti, M.S., L.Ac.
Inner Court Acupuncture*

Patient's Name _____ Date of Birth _____

Address _____

Phone # _____

Insured's Name (if different) _____

Relationship to Patient _____ Insured's Date of Birth _____

Insured's Address (if different) _____

Insured's phone # (if different) _____

Insurance Plan Name _____ Insured's Employer _____

Insured's Policy Group # _____ Insured's I.D. # _____

Insurer's Address _____

~If your insurance policy is qualified to cover my care, I will agree to bill your company directly. This is with the understanding that your insurance policy is a contract between you and the company - **I cannot guarantee payment of your claims.**

~If your insurance company pays only a portion of your bill, or rejects your claim, you are still financially responsible for the remainder of the claim.

~Please be prepared to pay the copay/co-insurance fee at the time of service.

~Please call 24 hours in advance to cancel or change your appointment or you will be charged a half-fee for that missed appointment. Insurance will not cover missed appointments; therefore the patient must cover the cost of missed treatments.

I encourage you to discuss with me any problems or questions that you might have about these policies, and appreciate your attention and care. Thank you~

Patient's Signature

Date