Back to Center, M.Ac, L.Ac | 29 Broad St. Suite 206, Berlin, MD 21842
443-844-7650 |backtocenteracupuncture@gmail.com|

Notice and Authorization for Insurance Billing

I, _____ *(print name),* do hereby give full permission and authorize Back to Center, L.Ac, to bill my insurance for services rendered by Back to Center, LAc. I also agree to have any checks or payment made by said insurance company to be payable and deliverable to:

Alison Leiner L.Ac

29 Broad st. Suite 206

Berlin, MD 21811

As a courtesy, my insurance will be billed directly by the insurance billing company employed by Back to Center, LAc. Prior to start of treatment (when possible), Back to Center, L.Ac will utilize her insurance billing company to call my insurance to verify my benefits, although benefits quoted by my insurance company are not a guarantee of payment. I am responsible for knowing the benefits my insurance policy covers. **Payments will be due at the time of service for any non-covered services, deductibles, coinsurance, or co-pays**.

I understand if I do not have insurance coverage, I will receive a cash discount. If I do have insurance that covers acupuncture treatment or other modalities, Back to Center, L.Ac will utilize her insurance billing company to bill my insurance for me at the full insurance fee rate. **I understand a full fee rate for services rendered is available upon request. I will be required to pay my insurance policies stated copay or coinsurance fee if required by my insurance, and/or the difference of the full insurance reimbursement and cash based fees.**

Fees:

As stated above, it is our policy that you pay the entire session fee or co-pay/deductible/coinsurance at the time of each session. We will provide a minimum of one month's notice of any changes to our fees.

Insurance Company _____

Insurance Company Phone Number (Provider Line) _____

ID # _____

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Please bring a photocopy of your insurance card (front and back) **or** bring your card to your first appointment so we can make a copy at the clinic.

Cancellation Policy:

If you need to change or cancel your appointment please notify us within a minimum of 24 hours notice. Failure to do so after 2 missed appointments will result in being charged the equivalent of the cash rate of the missed appointment to your account.

☐ **I understand the cancellation policy.**

Signature:_____ **Date:** _____/_____/_____

I understand the aforementioned office fees, insurance and billing policy. If my insurance is billed by this office, my billing statement will show "signature on file."

Please check one of the following:

____ I authorize Back to Center, L.Ac to bill my insurance and agree to the policy stated above.

____ I choose not to have my insurance billed for me and will pay cash or credit card for my treatments at the time of service. I agree to the fee policy's stated above.

_____ _____

Signature Date