AURA LENZ, L.Ac.

Financial Policies

Welcome to the office! Know that I will do everything I can to give you the best care possible. I am happy to assist you with any questions or concerns and to share my experience and knowledge.

Agreement By The Patient / Guarantor To Be Financially Responsible For Fees

I _____(patient or guarantor) understand that I am financially responsible for all charges including copayments, coinsurances, and deductibles as well as services not covered by my insurance plan. I understand that payment for services is due in full the day of treatment. I am aware that some and perhaps all of the services provided may be non-covered services under my insurance. I am also aware that verification of insurance benefits is not a guarantee of payment. In the event that my insurance denies my claim, I understand that payment in full is due at the time of receiving an invoice. I also understand that a monthly interest rate of 1.5% will be applied to any unpaid patient balance over 30 days past due. I am aware that payment must be made by check or cash. Initial: _____

Agreement By The Patient Regarding Cancelled/Missed Appointments

I understand that a missed appointment (No Show) will result in full charges being issued for that appointment. If I fail to give the clinic **48 hours notice** of a change of appointment, I may be charged for that appointment. Initial: _____

Medical Release To Insurance Company & Referring Physicians

I authorize the release of medical information to my insurance company / companies and referring physician, including diagnosis and the record of treatment or examinations rendered to me during the period of such medical care, and also request my insurance company / companies to pay directly to Aura Lenz for those medical services. Initial: _____

Agreement By The Patient for Text and Email Contact

I give my consent to receive appointment reminders via text message and email. Initial: _____

Notice Of Privacy Practices – Acknowledgement

- We keep a record of the health care services we provide.
- I may ask to see and copy that record.
- I may also ask to correct that record.
- My record will not be disclosed to others unless I direct the clinic to do so, or unless the law authorizes or compels the clinic to do so.
- I may see my record or get more information about it by contacting the Aura Lenz

Aura Lenz's Notice of Privacy Practices describes in more detail how my health information may be used and disclosed, and how I can access your information. I acknowledge that I have been provided with a copy of Aura Lenz's Notice of Privacy Practices to read. Initial: _____

_____ _____

Patient or legally authorized individual signature Date

_____ _____

Printed name and signed on behalf of the patient Relationship (Parent, legal guardian, representative)

_____

Witness/Staff Member