



*Patient Care Financial Agreement for Workman's Compensation*

We strive to provide quality affordable care with a great deal of personal time and attention given to each patient. For this reason, we have a firm **36-hour cancellation policy** for patient visits. Both private and Worker's Comp patient's who **cancel or no-show** for an appointment will be charged \$75 for a missed appointment and may lose one of their pre-authorized appointment times. This includes patient's who cancel after the close of business – 6 PM.

The cancellation policy is **strictly enforced** for all patients. After the second missed appointment, you will be referred back to your primary care provider for other care. Arriving more than 15 minutes after your scheduled appointment may count as a missed appointment.

**For patients with private insurance:** Billing for acupuncture is incredibly complex and your coverage must be verified PRIOR to billing. For this reason, new patients must pay the first visit in full, so that we may verify your coverage. Your PPO may only cover a portion of the services provided, and you are responsible for the balance of your bill. Be aware our Insurance rates are higher than our cash rates.

*Insurance is a service we provide but we are not obligated to do so. If at any time we determine that you do not have appropriate coverage or that your company is too difficult to work with, we will decline to provide this service and your bills will become due and payable in full.*

*I have read and understand the Patient Care Financial Agreement. I understand the Sharp-Rees Stealy and my WC carrier are not responsible for missed appointments. I understand that if my insurance is billed, I am responsible for services not covered by my insurance.*

Signature \_\_\_\_\_

Date \_\_\_\_\_

To expedite processing, we maintain a credit card on file. Please note that this card is only charged in the event of a missed appointment, and will be shredded at the completion of your treatment.

I hereby authorize the *Healing Arts Center of San Diego* and its agents to bill my credit card for charges incurred by me. I understand that I will be charged if I fail to give 36-hour notice for cancellations.

Print Name: \_\_\_\_\_  
(as it appears on card)

Address: \_\_\_\_\_  
(where credit card is billed)

CC #: \_\_\_\_\_ Expiration Date: \_\_\_\_ / \_\_\_\_

CDI #: \_\_\_\_\_ (on back of card)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_