

Privacy and Financial Agreement

By initialing below I, or on behalf of _____, acknowledge that I have reviewed, understand, and give consent to the following:

_____ **Acknowledgement of Privacy Practices:**

The Notice of Privacy Practices for Princeton Medical Acupuncture Center is available in writing. All necessary phone calls will be placed to the patient's home/cell phone number on record. If you object to receiving phone calls at this number, please provide an alternative phone number or email address.

_____ **Acknowledgement of Billing Practices:**

Charges for professional services are the responsibility of the patient regardless of insurance coverage. It is the insured's responsibility to understand their health benefits, including covered and no covered services, referral and authorization requirements, and network participation status of selected providers.

I hereby authorize payment from my insurance company for services rendered to be sent directly to Princeton Medical Acupuncture Center. If payment is not made at the time of service, I also authorize the release of medical or incidental information to my insurance company concerning my treatment. Further, by affixing my initials I assign the right to appeal insurance claims on my behalf. I certify that the insurance information provided by me is correct. I understand that I am responsible to comply with my insurance company's policy and insurance company or differential payment associated with tiered networks.

I understand that I will receive 3 statements and failure to remit financial responsibilities will result in the account being placed in collections to be accompanied by a \$25 placement fee.

_____ **Acknowledgement of Claim Status:**

The condition I am being treated for today is not the result of a work related injury or motor vehicle accident. I am aware that if my insurance denies payment to Princeton Medical Acupuncture Center because my condition was the result of a work related injury or a motor vehicle accident I will be responsible for payment to Princeton Medical Acupuncture Center within 30 days of such a notice, regardless of any pending legal action.

By signing below I validate my initials above and agree to the terms and conditions outlined herein.

Patient/Responsible Party Signature: _____ Date: _____