Authorization to Bill Third-Party Payer

Section A: Patient Information
Last name _____ First Name _____ Middle Initial _____
DOB _____ SS# _____
Daytime Phone (_____)_____

Section B: Billing Information

I. Primary Insurance Company & Plan Name:
_____
ID Number: _____Group/Policy Number: _____
Name of Policy Holder: _____
Policy Holder's Date of Birth:_____
The policy holder is my: _____ (specify relationship)
Policy Holder's Gender (circle): Male Female

II. Secondary Insurance Company & Plan Name:
_____
ID Number: _____Group/Policy Number:_____
Name of Policy Holder: _____
Policy Holder's Date of Birth: _____
The policy holder is my: _____ (specify relationship)
Policy Holder's Gender (circle): Male Female

Section C: Cancellation Policy, Medical Record Released Waiver, and Authorization to Bill Third-Party Payer

I, the undersigned, understand that all co-pays are due at the time of service and that I am financially responsible for all charges whether or not they are paid by my insurance. I understand that finance charges will begin accruing on accounts that are **60** days past due for payment at a rate of **1.5%** per month. I have also been informed of the $50.00 fee (per RCW 62A, 3-515 &520) on all checks returned by the bank for NSF, as well as the **$120.00 fee for less than 24 hours notice for cancellation of treatment.** I further understand that excessively overdue accounts will be forward to and outside collection agency and I will be responsible for any fees generated as a result of collection efforts. I understand that some third-party payers may require that my medical information, including copies of treatment notes, be submitted along with request for payment. I hereby authorize Ian Sok, EAMP, LAc and Absolute-cana acupuncture clinic, LLC to release all medical information necessary to secure payment of benefits from the third-party payers specified above, and I authorize the use of this signature on all related submissions. I understand that this information may include medical information related to drug and alcohol abuse, sexually transmitted disease, HIV/AIDS and mental health. I understand that this authorization shall remain valid without expiration unless expressly revoked by me in writing.

_____
Guardian/Personal Representative's Name (PRINT)

_____
Guardian/Personal Representative's Signature

_____
Relationship/Representative's Authority

_____
Date

Cancellation & Financial Responsibility Policy

1. I, the undersigned, understand that all co-pays are due at the time of service and that I am financially responsible for all charges whether or not they are paid by my insurance.
2. I understand that finance charges will begin accruing on accounts that are **60** days past due for payment at a rate of **1.5%** per month. I have also been informed of the $50.00 fee (per RCW 62A, 3-515 &520) on all checks returned by the bank for NSF, as well as the **$120.00 fee for less than 24 hours notice for cancellation of treatment.**
3. I further understand that excessively overdue accounts will be forward to and outside collection agency and I will be responsible for any fees generated as a result of collection efforts.

_____
Guardian/Personal Representative's Name (PRINT)

_____
Guardian/Personal Representative's Signature

_____
Relationship/Representative's Authority

_____
Date