ACUPROLO INSTITUTE
RESTORATIVE HEALTH & NONSURGICAL PAIN CENTER

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BILLING AND REIMBURSEMENT ACKNOWLEDGMENT

I, _____, acknowledge that:

- I understand and agree that, regardless of my insurance status, I am responsible for all charges incurred for professional services rendered at the time of treatment (cash or check only).
- I am aware there will be a $25 fee charged for checks with insufficient funds and that appointment cancellations need to be made prior to 24hours or I will be charged for the visit.
- I understand that if I arrive late for an appointment I will be seen only for the remainder of the time originally allotted for that visit and I am still responsible for the full cost of the visit.
- I am aware the payment fee schedule is as follows:
    - Initial comprehensive evaluation (up to 50mins) $150
    - Follow up evaluation with treatment (up to 50mins) ranges from $150 to $300 depending on the diagnosis and treatment modality
- I understand Acuprolo Institute does not accept payment from insurance carriers. However, upon my request, I will receive a superbill for the visit. It will be my sole responsibility to attempt to obtain reimbursement for services rendered.
- I understand that insurance reimbursement for injection therapies (prolotherapy, trigger-point injections, intramuscular injections, scar injections, joint injections, tendon injections, ligament injections, or neural injections) varies, and that some injection therapies may be considered investigational or experimental by some carriers and will not be paid for by the insurance companies. I further acknowledge that Medicare does not cover many injection therapies.
- I understand that insurance reimbursement for Traditional Chinese Medicine modalities (acupressure, acupuncture, electroacupuncture, moxibustion, and cupping) varies, and that some carriers will not pay for these treatments. I further acknowledge that Medicare does not cover these treatments.
- I understand that Acuprolo Institute is not responsible for any costs associated with treatment complications such as but not exclusive to hospitalizations, emergency room visits, costs incurred from other providers, laboratory and diagnostic imaging fees.
- I am aware the physicians in this office are not partners. They are independent practitioners and simply share office space, equipment and some staff in their separate practices. They are not responsible for each other's practice or patients, but may at times, cover for each other. Payments will be made to the primary doctor who provided care for that visit.

_____	_____	_____
Patient Name	Patient Signature	Date
_____	_____	_____
Parent or legal guardian name (If patient is a minor)	Parent or legal guardian signature (If patient is a minor)	Date