**KERRI KUHLSEN, L.Ac., C.SMA**
**TWIN ACUPUNCTURE**
**(917) 826-0054**
**33 Richmond Hill Road, Staten Island, NY 10314**

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During the course of your care, we may need to release information to other physicians and to your insurance company and we may also need to obtain information from other doctors that you have visited. We need to have a release signed that will enable us to do this on your behalf.

## Assignment of Benefits

I, ______________________________, authorize my insurance carrier ___________________________ to disclose to a health care service plan any medical information obtained if such disclosure is necessary to allow processing of the claim and facilitate my care. I also authorize my insurance carrier to pay this office directly for my bills incurred for services that are provided by this office under the terms of our policy. I understand that if my insurance carrier forwards reimbursement for services to me, that I will forward payment along with any explanation of benefits to Kerri Kuhlsen, L.Ac.

I understand that my insurance carrier policies are a contract between their agents and myself. I am responsible to assure that any amount not covered by my insurance carrier including, but not limited to, deductibles and co-payments will be paid by me to this office.

## Authorization to release medical information

I herby authorize the above named facility to release any and all records, medical history, services rendered or treatment given to me or any dependent for purpose of review, investigation or an evaluation of a claim submitted to my insurers.

| Patients Name: | |
|---|---|
| Patients Signature: | Date: |

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## *Confidentiality Agreement*

I, ___________________________________ understand that any information that I may encounter concerning patients, practitioners and staff's "protected information" will be treated as confidential.

"Protected information," means all health information past, present or future. It also includes demographic information that identifies a person or gives reasonable basis to believe the information may identify that person.

I will not remove any documents or materials from the office and at no time during or following my employment/contractual agreement will I use or disclose any confidential information.

I understand and agree to follow the terms and conditions of this confidentiality agreement. I further understand that a breach of confidentiality will result in the immediate termination of my employment/contractual agreement with you and the possibility of legal action being taken against me.

_________________________________
Signature

_________________________________
KERRI KUHLSEN, L.AC.
Licensed Acupuncturist

_________________________________
Printed Name

_________________________________
Date

_________________________________
Date

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# FINANCIAL AGREEMENT HEALTH INSURANCE

I would like to take a moment to welcome you to the office and assure you that you will receive the very best care available for your condition. In order to familiarize you with the financial policy of this office I would like to explain how your medical bills will be handled.

**EXPLANATION OF INSURANCE COVERAGE:**
Many insurance policies do cover acupuncture care but this office makes no representation that yours does. Insurance policies may vary greatly in terms of deductible and percentage of coverage for acupuncture care. Because of the variance from one insurance policy to another, it is required that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balances in this office. I will do my best to verify your insurance coverage, and will bill your insurance in a timely manner.

**PAYMENT ARRANGEMENTS:**
If an Explanation of Benefits is returned without payment from your insurance carrier, your portion of the bill is expected to be paid by the 15th day of each month, and any unpaid balances will be considered past due on the 15th day of the next month. Past due balances may have an interest charge of 1.5% applied per month.

**ASSIGNMENT OF BENEFITS:**
This designation directs your insurance company to send payments directly to this office. If your insurance carrier sends payment to you for services incurred in this office, you agree to send or bring those payments to this office upon receipt. If you pay for your visits in full, the assignment need not be signed and the payments will be sent directly to you from the insurance.

**RELEASE OF INFORMATION:**
If your insurance company requires medical reports to records to document your treatment progress, your signature below authorizes this office to release the medical information necessary to process your claim.

**VOLUNTARY TERMINATION OF CARE:**
If you suspend or terminate your care at any time, your portion of all charges for professional services is immediately due and payable to this office. All services rendered by this office are charged directly to you, and you, ultimately will be responsible for payment regardless of your insurance coverage.

I hope this answers any questions you might have concerning the financial policy of this office. Once again I welcome you to the office and will be glad to answer further questions that you might have.

**I HAVE READ AND AGREE TO THE ABOVE.**

____________________________ ____________________________
PRINT NAME DATE

____________________________ ____________________________
Signature Kerri Kuhlsen, L.Ac.