Sol Acupuncture LLC
Credit Card On File Policy

PAYMENT AND CREDIT CARD ON FILE POLICY

We are committed to efficiency and ease when it comes to billing and receiving payment for the medical care we provide. For all visits occurring after June 12, 2023, we require that you provide a credit card on file with our office. While we prefer that you continue to pay your account balances yourself, at your convenience, this policy will reduce staff time spent on collecting overdue balances and sending accounts to collections.

When scheduling or checking in, we will verify that you have a credit card on file, and, if you do not, we will store one on file for future transactions. Credit cards on file will be used to pay all account balances greater than 30 days that occur after insurance has finalized the medical billing claim, including co-insurance, co-payment, and deductible.
Credit cards on file will be used to pay the following charges as they occur: - East Asian Medical Services on-call non-covered services fee - Administrative document/task fees - Portal message fee - Late cancel/no show fee.

A couple of examples of how this works:
1) Once your insurance has processed our claim, they will send you an Explanation of Benefits (EOB) showing your total patient responsibility (i.e. the balance you owe). If you have a remaining balance due, you will receive an invoice from us. You may pay this invoice at that time. If the full payment has not been received within 30 days, your credit card on file will be charged up to the lesser of a) the balance due; or b) $200 per family member, each billing period (every month) until your balance is paid in full.
2) For services that include a fee at the time they occur, your card will be charged as soon as the service is completed. For example, as soon as East Asian medical advice is provided for uninsured patients, or Chinese herbs or other supplements are purchased, or a late cancellation is made (within 24 hours of appointment), or as soon as a document request is processed.
If your credit card expires or payment otherwise becomes uncollectible, you will be required to promptly provide a new means of payment. We do not accept HSA or FSA cards as your card on file, as they cannot be billed for late cancellation fees, after-hours medical advice, and administrative task fees; however, you can pay your invoice/bill, yourself with your HSA or FSA card for visit balances or co-insurance payments.

CREDIT CARD ON FILE AUTHORIZATION
I agree to place my credit card on file to be charged by Sol Acupuncture LLC. I authorize the use of my credit card for the purposes stated above.

_____ _____

Signature Date

Printed Name

INSURANCE AND SELF-PAY BILLING POLICY

You are required to provide proof of insurance coverage (insurance card) at the time of each visit. If the insurance information you provide is expired, invalid, or incorrect, you will be responsible for payment for any services rendered in full, which will be charged to your credit card on file.
If we are a participating provider (“in-network”) with your insurance carrier, we will submit your claim to insurance directly. According to your insurance plan, you are responsible for any and all copays, deductibles, coinsurance, and non-covered services. These amounts are determined by your insurance carrier’s medical benefits, not by our office. It is your responsibility to understand your medical insurance benefit plan.
Not all insurance plans cover East Asian medical care (and/or acupuncture). Coverage and benefits questions or disputes should be addressed to your insurance company, not to Sol Acupuncture LLC, office staff, or billing personnel.
If you are uninsured, do not have East Asian medicine or Acupuncture benefits, or are out of network with Sol Acupuncture LLC, payment for our East Asian medical services (including Acupuncture) must be made at the time

of service. All uninsured patients paying in full at the time of service will receive a preferential rate on visit fees. This discount does not extend to non-visit fees and supplements.

I agree to the above insurance and self-pay policies.

_____ _____

Signature Date

Printed Name

PRIVACY PRACTICES/HIPAA

We maintain a record of the health care services that we have provided to you. We will share this information, as permitted by law, to provide you with medical treatment, run our organization, and bill for these services. You have the right to view and obtain a copy of your medical records if needed. Our Notice of Privacy Practices document describes in more detail your rights to your health information and how this information may be used and disclosed. A copy of our Notice of Privacy Practices is available upon request. Sharing of your health information is typically used to improve the continuity of care that you receive. Common examples include sending immunization records to our state registry, use of a Health Information Exchange (HIE) with other health care organizations involved in your care, and accessing your prescription history from pharmacies. If you have questions or want to discuss options for decreased information sharing, please let us know.

I acknowledge that I have had the opportunity to reviews the privacy practices/HIPAA policy.

_____ _____

Signature Date

INFORMED CONSENT

I consent to the plan of care proposed by Sol Acupuncture LLC. I understand that I, or my authorized representative, have the right to decide whether to accept or refuse this plan of care. I will ask for any information I want to have about my medical care and will make my wishes known. I understand that Sol Acupuncture LLC participates in the training of East Asian Medical Care providers and I consent to their involvement in my care. I understand that the practice of East Asian medicine or Acupuncture is not an exact science and acknowledge that no guarantees have been made to me regarding the likelihood of success or outcomes of any examination, treatment, diagnosis or test performed by Sol Acupuncture LLC.

I consent to the above Informed Consent:

_____ _____

Signature Date

I am hereby electronically signing and acknowledging that I have read and fully understand the above Clinic Policies. I agree to the above stated information.

_____ _____

Signature (or type name if electronic form) Date

_____

Printed Name