The Acupuncture Clinic of Missoula
Health Options Clinic 3031 S. Russell St. Ste1 Missoula, MT 59801
www.acupunctureclinicofmissoula.com
406-728-1600

Financial Agreement

Fees for Services:* **	**Standard Billing Rate**	**Paid in Full at Time of Service Discount**
New Patient	$144.00	$125.00
Return visits	$94.00	$80.00

*** Prices may change over time and without notice.
*Senior Citizen Discount (65 years and older): $10.00 off per visit.
*Children Discount (15 years and younger): $20.00 off per visit.
*Only applicable to time of service fee. Does not apply to standard billing rates.

I agree to the following: **(please check one)**

____ **I will pay in full at time of service**.
*We accept cash, check, Visa, MasterCard, Discover, AMEX.

____ **I request that my insurance company be billed**. I will pay my co-payment at the time of service. I understand that this will be billed at the standard billing rate and will not reflect the time of service discount.
*Any charges remaining after receipt of insurance payment must be paid within 30 days.

____ **I request that the insurance company for the person at fault** (related to motor vehicle accident or other personal injury) **be billed for all charges.** I understand that this will be billed at the standard billing rate and will not reflect the time of service discount.

____ **I request that Worker's Compensation be billed.** I will pay charges for herbal medicine and supplies not covered by Worker's Compensation. I understand that this will be billed at the standard billing rate and will not reflect the time of service discount.

Unless covered by a third party, patients are expected to pay in full at the time of service.

- I understand that I am ultimately responsible for all costs of my treatment.
- **I understand that the Time of Service Fee is only applicable if paid at the time of service, and will not be offered if insurance is billed**.
- I understand all balances are subject to a billing charge of $5.00 per month.
- I assign my insurance benefits to the Acupuncture Clinic of Missoula.
- I give my permission to the Acupuncture Clinic of Missoula to disclose complete information concerning my medical treatment to the insurance carrier being billed for charges.
- I understand this form is valid unless I cancel authorization through written notice.
- I understand that if a payment is not made on outstanding balances within 90 days, my account will be considered delinquent and turned over to a collection agency.
- I understand that I am responsible for any collection costs incurred on my account, including reasonable attorney's fee.

Signed____

Date_________________