Financial Obligation

Please note all payment is due at the time of service. If payment cannot be made or total due is unknown at time of service, a bill will be directed to the mailing address on file. Payment is expected upon notice of amount due.

This office is contracted with multiple insurance plans. All patients are expected to provide our office with current insurance information, verification of participation, identification, and to understand their benefits. PNT acts as an advocate for our patients with their managed care plans. This may include completing verification and eligibility paperwork on behalf of the patient. Ultimately, the patient is responsible for understanding their benefits and providing our office with current information so that we can handle this paperwork on their behalf in a timely manner.

- Your insurance may not cover the best and recommended plan of care. To achieve optimal results, we recommend a minimum of 4 visits per week. If you would like to discuss other options, please inquire with the front desk.
- Patient Responsibilities: patient-pays, coinsurance, deductibles, and all other procedures or treatment not covered by their insurance plan.
- Payment is due at the time of service, for your convenience we accept cash and most major credit cards at our office.

At PNT, we stick to a strict schedule; appointment times are limited and we count on you being on time and present for every scheduled visit. We will bill patients for being late, for cancelling an appointment without sufficient prior notice and for not showing up.

- **Late Fee: $30** - If you're 15+ minutes late for an appointment.
- **Cancellation Fee: $50** - Cancellation *must* be made by 8:30am the day of your appointment. Please note that if your appointment is before 1pm, you must cancel the night before.
- **No Show Fee: $150** - If you don't show up for an appointment and fail to cancel ahead of time, you will be charged for the session.

Our responsibility is to maintain your health and well-being. Your health insurance is a contract between you and your health insurance company. You are financially responsible for any non-covered services. By signing our Consent Acknowledgement Form, you acknowledge you agree and fully understand the Financial Obligation Policy.

HIPAA (Health Insurance Portability and Accountability Act)

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payments from third-party payers and conduct normal healthcare operations such as quality assessments and provider certifications.
- I understand that as part of my healthcare, Pacific Neuro Therapy originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

Contraindications

By signing this form, I am agreeing to the following:

- I do not have a pacemaker
- I do not have a defibrillator
- I do not have any chance of pregnancy
- I have not had an occurrence of blood clots within the last 12 months.

Patient Name: ____________________________

Patient Signature:__________________________

Date:____________________________________

****** By signing our Consent Acknowledgement Form, you acknowledge, agree to and fully understand the Health Insurance Portability & Accountability Act.