



**Acupuncture Insurance Verification Patient Acknowledgement**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

First Acupuncture Evaluation/Treatment Date: \_\_\_\_\_

**\*\*Cash Price: \$150 Initial Evaluation/Treatment. \$100 Follow Up Treatment.**

**It is the responsibility of each patient to verify that acupuncture benefits are included in their personal insurance policy.**

**I acknowledge Emergency Responders Health Center has informed me (the responsible party) of my financial responsibility should my insurance not cover my acupuncture initial evaluation and subsequent treatments.**

**I assume full financial responsibility for the balance of charges not covered by insurance.**

Patient or Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Front Office Signature: \_\_\_\_\_ Date: \_\_\_\_\_