Medical Acupuncture Financial Responsibility Consent Form Patient Information:
Full Name: _____
Date of Birth: _____
Address: _____
City/State/ZIP: _____

Health Insurance Information:
Insurance Provider: _____
Policy Number: _____
Group Number: _____

I, the undersigned patient, hereby acknowledge and agree to the following terms regarding the financial responsibility associated with medical acupuncture treatment at San Mateo Spine Center:

Insurance Coverage Verification: I understand that it is my responsibility to verify and understand the extent of coverage provided by my health insurance plan for medical acupuncture treatments.

Financial Responsibility: I acknowledge that I am financially responsible for any costs related to medical acupuncture treatment that are not covered by my health insurance plan. This includes, but is not limited to, deductibles, co-payments, and any services deemed as not covered by my insurance provider.

No Disputes with San Mateo Spine Center: I agree not to argue, dispute, or hold San Mateo Spine Center responsible for any lack of acupuncture coverage or denial of claims by my health insurance provider.

Payment Agreement: I agree to promptly pay/settle all charges related to medical acupuncture treatments, either covered or not covered by my health insurance, in accordance with the payment terms established by San Mateo Spine Center.
Updates to Insurance Information: I will promptly inform San Mateo Spine Center of any changes to my insurance coverage or personal information that may affect billing and reimbursement.

Patient Signature: _____ Date: