# Financial Policy

 Payment is due at the time of service, unless otherwise arranged. As a courtesy, in most cases, we will bill your insurance but you are ultimately responsible for any payment due to Bellingham Bay Acupuncture PS or Jill A. Likkel. Any insurance that you may have is an agreement between you and your insurance policy. Please note that not all conditions are covered by insurance for acupuncture treatment. It is your responsibility to know and understand your insurance policy. You should call your insurance company to find out what is covered under your policy.

**Initial**_______I do agree to pay Bellingham Bay Acupuncture PS/Jill Likkel LAc for services and any supplements purchased. I am responsible for my bill whether or not insurance has been billed. I understand and agree that all services rendered to myself are charged directly to me and that I am personally responsible for my account.

**Initial**______ I agree to keep my account balance current by paying for services, supplements, co-pays or coinsurance at each visit.

**Initial**________An accounting service charge of 1.5% will be added to accounts over 30 days past due. Should this account be turned over to collections for any reason, reasonable collection costs may be added to accounts requiring such third party expenses. Unpaid fees over 90 days will be sent to collections or filed in court, unless prior arrangements have been made and past due accounts are kept current.
In the event that unpaid fees are sent to collections, the patient agrees to pay all collection fees. In the event that legal action is filed, the patient agrees to pay reasonable attorney fees, filing fees and other costs the court deems.

 **We require a 24 hour notice for any schedule changes**. You are responsible for remembering your own appointments. A “no show” fee is the amount of a normally scheduled visit and is not covered by insurance companies, and must be paid by the patient.
**Initial**____________ I understand that if I do not adhere to my appointment schedule as agreed upon, and do not make prior arrangements **24 hours in advance, I will be charged for the time reserved.**
I understand that rescheduling and canceling appointments must be done 24 hours in advance at our number **360-483-3728**. Phones are open 24 hours a day, seven days a week. Exceptions are made for emergencies only.

**NOTICE OF PRIVACY PRACTICES**
**Initial**_________ I acknowledge that I have been offered a copy of the Notice of Privacy Practices to read and/or take home. (A copy is always kept posted on the wall of this office if you wish to re-read it. Please feel free to ask any questions about it.)

Signature Date