Dr. Lesley Castellini, LAc
Erica Castellini, LCSW, LAc

Acupuncture / Active Release Techniques

www.castellinicare.net

Notice of Financial Responsibility

We go to great lengths working with insurance companies to ensure payment for the treatment that is best suited for your wellness. However, each patient's coverage is different. Therefore, **it is imperative that you are aware of your acupuncture and/chiropractic coverage**.

It is your responsibility to obtain referrals if required by your plan. You will be financially responsible for services provided if you have not obtained a required referral.

If insurance payments are sent to you, you are responsible for forwarding them to our office.

I understand that I am financially responsible if services recommended and agreed to are not covered under my health plan, if my eligibility is not confirmed prior to treatment, if charges exceed my plan's maximum benefit or if my insurance is terminated.

I agree to the above financial policy. I hereby authorize the release of any medical or other information necessary to process the insurance claims by the healthcare practice named above.

Assignment of Benefits

I authorize payment of medical benefits to the physician or supplier for services rendered.

Notice of Privacy Practices

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (**HIPPA**), I have certain rights to privacy regarding my protected health information. I further understand that this information can and may be used for any of the following:

- To conduct, plan and direct my care and follow-up with the multiple healthcare providers who may be directly or indirectly involved in the treatment(s)
- To obtain payment from third party payers (insurance, etc.)
- To conduct normal and required health care operations such as quality assessments and physicians certifications

I have been informed by Lesley Castellini, LAc, DC, LLC and/or Erica Castellini, LCSW, LAc, of their **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I have had the opportunity to review the entire **Notice of Privacy Practices** prior to signing this consent.

I have read and agree to all of the above disclosures.

Print Name _____

Signature _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____