East West Medicine☯

Kim Nguyen, L. Ac.

Appointment and Financial Policy

Thank you for choosing East West Medicine to enhance your health and well-being. We strive to provide excellent medical care to our patients as well as a delightful experience. Please take a few moments to read over our appointment and financial policy, so that we can ensure the convenience of our patients and staff.

Appointment Policy

* Please provide us with 24 hours notice if you cannot keep your appointment. Kim Nguyen reserves the right to charge you a fee of $70.00 for a missed appointment. Medical emergencies, death of a loved one and inclement weather are the only exceptions. We value your time at each visit and will be happy to assist you in rescheduling.
* If you expect to be more than 15 minutes late, please call to confirm availability. If we cannot see you due to your tardiness, you will be charged $70.00.

Financial Policy

The responsibility of the patient is to provide payment at the time that services are rendered. Kim Nguyen reserves the right to withhold and/or terminate treatment indefinitely if a patient does not pay for the services. Payment is accepted in the form of cash, Visa, Mastercard & American Express.

In the case that patients have In-Network insurance coverage, we will submit a claim to your insurance company. The patient is responsible for the bill and any outstanding balances, deductibles and copayments. Any overcharges by Kim Nguyen will be reimbursed to the patient after the claim has been processed. It is advised that you review your benefits and have it in writing in the event that insurance denies acupuncture services.

In the case of Out-of-Network benefits, you may request a Superbill in order to submit for reimbursement. It is advised that you ask your insurance company how much they are willing to pay for an out-of-network provider, and receive this information in writing, fax or e-mail.

I have read and fully understand the appointment and financial policy. Any questions I have concerning my appointments have been answered.

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Signed Date

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Printed Name of Patient or Representative Relationship

I authorize the provider to release any information required to process any insurance claims. I permit a copy of this authorization to be used in place of the original.

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Signed Date