Acupuncture
Thrive Integrative Medicine LLC
Patient Demographic Form

Patient Legal Name: _____ Date of Birth: _____ Gender: **F** **M** **Other**

Patient Preferred Name: _____ Marital Status: **M** **S** **Other**

Is the patient aminor? **Yes** **No** If yes, parent / guardian name(s):_____

Mailing Address: _____ City, State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Preferred phone? **Home** **Cell**

Preferred reminder method? **Call (Home)** **Call (Cell)** **Text Cell** **Email**

Email address: _____ Is it okay to contact you via email? **Yes** **No**

Employer: _____ Work Phone: _____

Spouse Name:_____ Phone: _____

Emergency Contact Name:_____ Relationship: _____

Emergency Contact Phone Number (s): _____

How did you hear about us? _____

Is this a workers comp or personal injury claim? Yes No

PRIMARY INSURANCE INFORMATION:

Company Name: _____

Primary Policy Holder Name: _____ DOB: _____

Patient Relationship to Primary Policy Holder: **Self** **Spouse** **Child** **Other**:_____

ID #: _____ Group #:_____

SECONDARY INSURANCE INFORMATION:

Company Name: _____

Primary Policy Holder Name: _____ DOB: _____

Patient Relationship to Secondary Policy Holder: **Self** **Spouse** **Child** **Other**:_____

ID #: _____ Group #: _____

3835 Spenard Rd, Anchorage, AK 99517
P (907) 274-9355 F (907) 274-9345

Insurance Verification Form

Thrive Integrative Medicine
3835 Spenard Anchorage, AK 99517
Phone: (907)274-9355 Fax: (907) 274-9345
Email: hello@thriveak.com

*Please complete and return to Thrive before your first Massage Therapy/ Acupuncture appointment. *

Thrive Integrative Medicine recommends that every patient call and verify that medical massage/acupuncture is covered by their insurance policy. The Member Services phone number can be found on the back of your insurance card.

The following information is helpful when verifying coverage:

1. The service is rendered by a Licensed Massage Therapist/Acupuncturist.

2. The service is performed in a stand-alone facility, without supervision.

3. The therapy has been ordered by a provider, and is part of a treatment plan.

Patient Name: _____ DOB:_____

Insurance Company: _____ Member ID #:_____

Call Reference Number: _____ Agent Name: _____

Massage Therapy coverage: Yes or No

97140 Manual Therapy Code *(this code is for all Thrive massage therapy services, i.e. rolfing, craniosacral, and myofascial therapy)*

Coinsurance: _____ Copay: _____ Visit Limit: _____ Used: ____

Referral Required: Yes or No Prior Authorization Required: Yes or No

Acupuncture Coverage: Yes or No

97810 Acupuncture w/o e-stim. 97811 Acupuncture w/o e-stim additional 15 minutes,
97813 Acupuncture w/ e-stim, 97814 Acupuncture w/ e-stim additional 15 minutes
97026 Infrared Therapy- TDP, moxibustion

Coinsurance: _____ Copay: _____ Visit Limit: _____

Referral Required: Yes or No Prior Authorization Required: Yes or No

Are there any requirements for coverage (such as prior authorization or documentation of medical necessity, chiropractic same day visit)?:

_____

_____

Thank you for choosing Thrive to be a part of your health care team!

Please provide the Front Desk with your ID Card, as well as insurance card(s) including any Medicare / Medicaid cards if applicable.

PAYMENT FOR SERVICES:

Please read, initial where indicate, and sign below.

PATIENT RESPONSIBILITY: (please initial on each line)

_____ Insurance is not a guarantee of payment.

_____ We cannot accept Tri Care, Denali Kid Care, Medicare, Medicaid, or AARP Supplemental Plans.

_____ It is your responsibility to call your insurance company prior to your appointment to determine if your visit will be covered.

_____ We will try to let you know if you have an insurance company that will not cover naturopathic visits (these include UMR, Aetna Conoco Phillips and Aetna Tesoro). If your company does not generally reimburse for naturopathic visits, you may be asked to pay up front while the claim is being filed.

_____ We will bill your insurance if you present your insurance cards at the time of your appointment. It is important for you to know that we are not always contracted with your insurance carrier. This means that you are responsible for monitoring the processes of your insurance company to make certain your claim is processed in a timely manner, for contacting them if you have questions as to how your claim was processed, and that you are ultimately responsible for payment of services rendered.

_____ If you have a personal injury or workers comp claim, you will be responsible for the charges at the time of the visit. We will give you the paperwork so you can file for reimbursement with your insurance company.

_____ Any co-payments or "patient responsibility" percentages must be paid at the time of service.

_____ If we do not receive a response from your insurance company within 45 days from the date we bill them, the balance will become your responsibility.

_____ You will receive a statement for any remaining balance after all applicable insurances have been applied. That balance is due in full at that time.

_____ If we do not receive your payment in full within 90 days from the date of the first statement or have not heard from you about setting up a payment plan by that time, your account may be turned over to a third-party collection agency.

_____ Injections and dispensary items are not covered by insurance and must be paid in full at the time of the visit.

We accept cash, checks, and all major credit cards. If a payment in check form is returned to us because of insufficient funds, you will be charged a $25 fee. Payment in full at the time of service is required in the following circumstances:

- You do not have insurance coverage, or are covered by a plan we are unable to accept
- You are covered by a personal injury or workers comp claim
- You have not brought your insurance cards with you
- You have not met your deductible
- A contract is required by your insurance policy and we are not contracted with your insurance carrier
- For dispensary items, injections, or other procedures or treatments not covered by insurance

By signing below, you acknowledge that you have read and understood the above statements and are willing to accept responsibility for services rendered if not covered by insurance. You also understand that you are responsible for laboratory charges not covered by insurance. This authorization is not limited in time.

_____ _____

Patient Signature (or responsible party) *Date*

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ACUPUNCTURE PATIENT CONSENT AND ACKNOWLEDGEMENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patients Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent.

This consent form, when signed, gives us permission to release necessary medical information to your medical insurance provider to process your claim, as well as to the pathologist, lab, or other doctor(s) who may be consulted in your diagnosis and treatment. Each of the above will also treat your information with the strictest confidence. This signed consent form gives us authorization to provide your information to a specific person other than yourself. Your information is otherwise confidential.

By signing below, you understand that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- Thrive Integrative Medicine has a Notice of Privacy Practices and you have the opportunity to review this Notice.
- Thrive Integrative Medicine reserves the right to change the Notice of Privacy Practices. If we change our Notice, you may obtain a revised copy by contacting our office.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- Thrive Integrative Medicine may alter provision of services upon the execution of this Consent.
- In addition, you acknowledge receipt of the Notice of Privacy Practices provided to you today.

Do we have your permission to:

Leave a message on your cell phone? ☐ Yes ☐ No

Leave a message on your answering machine at home? ☐ Yes ☐ No

Discuss your medical condition with any member of your household? ☐ Yes ☐ No

If yes, whom: _____

Relationship: _____

Contact you by text? ☐ Yes ☐ No

Consult within Thrive Integrative Medicine? ☐ Yes ☐ No

_____ _____

Signature of Patient or Personal Representative | Date

_____ _____

Printed Name of Patient or Personal Representative | Relationship / Description of Personal Representative's Authority

_____ _____

Signature of Witness | Date

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General Liability Release Form

By signing below, you agree to the following:

1) I give my permission to receive acupuncture.
2) I understand that acupuncture is not a substitute for traditional medical treatment or medications.
3) I understand that the Superficial bruising does not diagnose illnesses or injuries, or prescribe medications.
4) I have clearance from my physician to receive acupuncture.
5) I understand the risks associated with acupuncture include, but are not limited to:
    - Short-term muscle soreness
    - Exacerbation of undiscovered injury.
    - Superficial bruising/bleeding

    I therefore release the company and the individual acupuncturist from all liability concerning these injuries that may occur during the session.
6) I understand the importance of informing my acupuncturist of all medical conditions and medications I am taking, and to let the acupuncturist know about any changes to these. I understand that there may be additional risks based on my physical condition.
7) I understand that it is my responsibility to inform my acupuncturist of any discomfort I may feel during the acupuncture session so he/she may adjust accordingly.
8) I understand that I or the acupuncturist may terminate the session at any time.
9) I have been given a chance to ask questions about the acupuncture session and my questions have been answered.

_____ _____

Signature Date

THRIVE INTEGRATIVE MEDICINE
APPOINTMENT CANCELLATION POLICY

Thrive Integrative Medicine understands how valuable your time is, and we appreciate the fact that you take time out of your busy life and choose to make an appointment with a Provider here at Thrive. Our Providers work diligently to make sure that they keep their appointments if at all possible, and give ample notice when appointments need to be canceled or moved.

If a Patient needs to cancel or reschedule their appointment, Thrive requests that action be taken more than 24 hours prior to the scheduled appointment time. If an appointment is canceled within less than 24 hours notice, Thrive may, at the discretion of the Provider, charge a cancellation fee. Cancellation fees are not covered by insurance, and will be the responsibility of the patient. A fee of $100.00 may be charged for a cancellation that occurs less than 24 hours before an appointment. (please leave us a voicemail if your appointment is scheduled on a Monday.)

Attention New Patients A $100 deposit will be required for all new patients at time of scheduling. The card will only be charged if patient no shows to their first appointment or cancels without 24hr notice.

If a Patient does not show up for their scheduled appointment, a No-Show fee will be charged to that Patient. No-show fees are not covered by insurance, and are the financial responsibility of the Patient. No-show fees will be charged as follows:

- No-Show Fee — $100
- Late Cancellation Fee — $100
- Third occurrence — Potential discharge from practice

Thrive and all its Providers understand that emergencies happen, and if an emergency causes a Patient to no-show for an appointment, the no-show fee will be waived for that occurrence, however repeated No-shows for any reason are potentially cause for discharge of Patient from Practice. Thrive works diligently to keep the communication open and clear between Patient and Provider and Support Staff. Please let us know what your situation is!

Signing below indicates that you have read the above cancellation policy and that you agree to the terms and conditions stated in this policy.

_____ _____

Patient Name (Please Print) Date of Birth

_____ _____

Patient Signature Date