

Alliance Wellness Center Inc.

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About acupuncture and insurance

In this day and age many insurance companies cover acupuncture. How they cover acupuncture varies quite a bit. Some insurance companies draw only from a finite panel of acupuncturists. Some restrict what conditions are to be treated with acupuncture. Some limit the dollar amount of coverage per year. Insurance coverage changes from year to year and sometimes every few months. Because of the wide variety of acupuncture coverage we highly recommend you check with your insurance company to ensure that your plan covers acupuncture and that you fully understand what your coverage is. Additionally, you should verify that Donna Stancil is a provider covered under your plan.

Insurance billing

Our office is equipped to bill insurance companies directly and we are happy to offer this service to our clients. It is important however, that you (the patient, or other party responsible for the account) understand that your insurance policy is an agreement between you and your insurance company, and that you are personally responsible for all of the charges to your account should your insurance company refuse payment for services rendered. If after 90 days, we have not received full payment or have only received a partial payment from your insurance company, you will be billed for any outstanding or remaining balance. All deductibles, co-payments and 'patient portions' are due at time of service.

Medicare does not cover acupuncture and our office does not contract with them. However, your private insurance company may require that we submit claims to Medicare before they can be considered for payment. You must let us know if you are dually covered by both private insurance and Medicare. Please provide us with your Medicare information at the bottom of this form under 'secondary Insurance'.

Please fill out the section below if you would like us to bill your insurance company

Patient's information

Name: First _____ Middle Initial _____ Last _____ DOB _____

Address: Street _____ City _____ State _____ ZIP code _____

Status: (please circle): M W S P (legally partnered) **Employed:** Y N, Full or Part-Time **Student:** Y N, Full or Part-time

Employer or School's name _____ **Insurance plan or program name** _____

Policy # _____ **Group #** _____ **ID #(if any)** _____

Insurance Co: _____ **Phone:** _____

Where should claims be sent: Address: _____ City: _____ State: _____ Zip: _____

Insured's information (if different from 'Patient's' info above)

Name: First _____ Middle Initial _____ Last _____ DOB _____

Address: Street _____ City _____ State _____ ZIP code _____

Status: (please circle): M W S P (legally partnered) **Employed:** Y N, Full or Part-Time **Student:** Y N, Full or Part-time

Employer or School's name _____ **Insurance plan or program name** _____

Policy # _____ **Group #** _____ **ID #(if any)** _____

Insurance Co: _____ **Phone:** _____

Secondary Insurance, including Medicare

Name: First _____ Middle Initial _____ Last _____ DOB _____

Address: Street _____ City _____ State _____ ZIP code _____

Status: (please circle): M W S P (legally partnered) **Employed:** Y N, Full or Part-Time **Student:** Y N, Full or Part-time

Employer or School's name _____ **Insurance plan or program name** _____

Policy # _____ **Group #** _____ **ID #(if any)** _____

Insurance Co: _____ **Phone:** _____