HermitsPointMedicine.com
720-629-4211

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OFFICE POLICIES AND INSURANCE CODES

CANCELLATION and MISSED APPOINTMENTS: Please provide 24 hour notice of cancellation prior to your scheduled appointment. If you miss an appointment or cancel within 24 hours you will be charged a $50.

REASONS FOR BEING DISMISSED/DENIED TREATMENT: Patients who show inappropriate conduct, non or late payment of fees, or safety concerns may be denied treatment.

FINANCIAL POLICY: Payment is due in full at the time of service.
For your convenience, we accept cash, check or credit cards.
For checks returned to us as unpaid by your bank, you will be charged a $50 fee.

INSURANCE POLICY: Many Insurance companies cover acupuncture. Please check with your carrier and particular plan.
You are responsible for your deductible, copayment, and any non-covered or excluded amounts under your policy. If your insurance denies payment of a claim you are responsible for billed charges. In the case that your insurance company sends a check directly to you for the payment of the treatment, you agree to endorse the check to Hermits Point Medicine and turn over payment with accompanying Explanation of Benefits form.

Procedure Code	Description of Service	Billed Charge
99203	New Patient Evaluation	$100
97810	Acupuncture, first 15 minutes	$80
97811	Acupuncture, additional time	$60
97014	Electric Stimulation	$60
97016	Cupping Therapy	$60
90901	Bio-Feedback Therapy	$80
90832	Psychotherapy (16-37 minutes)	$80
90834	Psychotherapy (38-52 minutes)	$60
90837	Psychotherapy (53+ minutes)	$60
90875	Psychophysiological with biofeedback (20-30)	$80
90876	Psychophysiological with biofeedback (45-50)	$60
97010	Massage Hot/Cold Pack	$40
97124	Massage	$80
97140	Massage Manual Therapy (neuromuscular) (15 minute)	$80
-52	Reduced service modifier	Time based

RECORDS RELEASE & ASSIGNMENT OF INSURANCE BENEFITS: The undersigned hereby authorizes the release of any information to claims for benefits submitted. I further agree and authorize the above practitioners to submit claims for benefits, for services rendered, without obtaining my signature on each claim. I understand that I am financially responsible for all charges incurred, whether or not they are covered by my insurance company. This authorization shall remain valid until written notice is given by me revoking said authorization.

Please indicate your understanding and acceptance of these office policies by signing below.

PATIENT SIGNATURE____________________________________**DATE**______________________