Points of Origin, PLLC
18810 NE 18th Street
Vancouver, WA 98684-0969

Peter Hanfileti, MD
Lisa Hanfileti, LAc
(360) 449-4500

Financial Agreement, Cancellation & Privacy Policy

It is our goal to help you understand your financial responsibilities before treatments begin. *Please read the following agreements carefully, initial each portion and sign at the bottom of the page.* If you are unclear about any of our policies, please do not hesitate to ask us questions. Payments (including copays) may be in the form of check, cash, debit, Visa, MasterCard, Discover, American Express, most HSA cards or online via Paypal.

In general, there are two payee categories; (1) Self Pay, i.e. no insurance benefits for acupuncture, or (2) Insurance Billing for acupuncture and/or office visits. A patient who has used their insurance benefits for the year becomes a Self Pay patient. Regardless of which category you fall into, we have one Fee Schedule for everyone (available upon request). Your billed amount will depend on the services we provide and the time it takes to provide these services at each visit (for example, acupuncture, infrared light/heat therapy, cupping, localized massage, electro-stimulation, *gua sha*, nutritional counseling, and other therapies within our scopes of practice.) We do not charge or bill for the time that you spend resting in the treatment room once the acupuncture points are paced. In most cases we only charge/bill for the time we spend with you performing procedures. Herbs, vitamins, supplements, essential oils, books, and other materials are priced individually and are not billed to your insurance.

PLEASE READ & INITIAL EVERY SECTION WHERE INDICATED THEN SIGN BELOW

FINANCIAL AGREEMENT: Please call our office so we can give you a firm estimate on the fee you are expected to pay at the time of service. In general, a new patient 90-120 minute adult visit costs between $135 and $165, with an average payment of **$150**. Follow up visits are 30 to 60 min and cost between $55 and $95, with an average payment of **$80**. If you are a Senior (over age 60) or a Child (age 13 or younger), follow up visits average **$70** with the range between $55 and $115.

Copays are due at the time of service. If you have co-insurance or any uncovered costs, you may choose to make an estimated payment at the time of service or be billed for the exact amount once the Explanation of Benefits (EOB) is available. If we are contracted with your insurance provider we are obligated to submit your visits to your insurance company even if your payments go toward your deductible. We will do our best to get an estimate of your "Patient Responsibility" for our services prior to submitting to your insurance, however we will not know your exact balance until your insurance company sends us (and you) an Explanation of Benefits (usually 14-30 days after billing).

Although we do our best to get the most accurate information from the resources available to us as providers, we cannot guarantee your insurance company's payment for our services. You are ultimately responsible for any balances due to Points of Origin, PLLC, Peter Hanfileti, MD or Lisa Hanfileti, LAc. We recommend that you call your insurance company (phone number on your insurance card) and ask what is covered under your policy. Specifically, ask if you have acupuncture benefits, what is your co-pay , do you have co-insurance, do you have a deductible to meet (if so, how much?), is acupuncture subject to your deductible (often it is not) and ask if there are any unique conditions that may impact your coverage for treatment at our clinic. Be sure to confirm if we are considered in or out of network providers and if office visits are covered. We recommend that you document the date, name of the person you spoke with and the detailed information they gave you.

Initial_____ I understand that payment is due at the time of service.
Initial_____ [Assignment of Benefits] From this date forward, I authorize that payment of medical benefits be made directly to Points of Origin, PLLC. If my insurance company erroneously sends payments to me for services provided by this office, I agree to send/bring those payments to Points of Origin, PLLC upon receipt. I acknowledge and request that payment of government benefits be made to Points of Origin, PLLC for health care services rendered.
Initial_____ [Release of Information] From this date forward, I authorize Points of Origin, PLLC , upon request of my insurance carrier, to release any medical or other information to process the claims they submit for me.

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Initial_____ I give Points of Origin, PLLC permission to bill my insurance. I understand that copays are due at the time of service and I have the option of paying estimated co-insurance and other balances at the time of service or later when the EOB is available.
Initial_____ I give Points of Origin, PLLC permission to email me receipts or statements to the email address provided on the Patient Registration & Intake form through their accounting program. I can opt-out of this at any time.

BALANCES DUE & CREDITS
Initial_____ I understand that I may occasionally have a balance due and agree to pay within 30 days of learning about any unpaid balance. I understand and agree that all services rendered to myself (whether billed to insurance or not) are charged directly to me and that I am personally responsible for my account.
Initial_____ An accounting service charge of 1.5% will be added to accounts over 30 days past due. Should this account be turned over to collections for any reason, reasonable collection costs may be added to accounts requiring such third party expenses. Unpaid fees over 90 days will be sent to collections or filed in court, unless prior arrangements have been made and past due accounts are kept current. In the event that unpaid fees are sent to collections, the patient agrees to pay all collection fees. In the event that legal action is filed, the patient agrees to pay reasonable attorney fees, filing fees and other costs the court deems.
Initial_____ I understand that there are times when I may have a credit (e.g. due to overpayment of estimated services, product return, etc). I give Points of Origin, PLLC permission to apply the credit to my next visit(s) or product purchase. I may also choose instead to have a check issued to me for the full credit amount.

CANCELLATION & NO-SHOW POLICIES: We require a 24 hour notice for any schedule changes including cancellation by calling our office at 360-449-4500. Phones are open 24 hours a day, seven days a week. Exceptions are made for emergencies only. We offer a free automated appointment reminder system however you are responsible for getting to your appointments on time. A $25 cancellation fee will be billed to you if you cancel with less than 24-hours AND we are unable to fill your appointment time. (We do have an active cancellation list and make every effort to fill cancelled appointments. If we fill the appointment, you will not be charged a fee.) If you miss your appointment without notifying us in advance, a "no show" fee of $25 will be billed to you. Repeated no-shows may result in you being discharged from our practice.
Initial_____ I understand that rescheduling and canceling appointments must be done 24-hours in advance by calling 360-449-4500 otherwise I will be billed $25 per visit.
Initial_____ I give Points of Origin, PLLC permission to use their automated appointment reminder system to call & email me at the phone number and email address provided on the Patient Registration & Intake form. I may opt-out of the automated phone and/or email appointment reminders at any time.

NOTICE OF PRIVACY PRACTICES [HIPAA]
As health care providers, we keep a record of the health care services we provide to you. You may ask to see a copy of your record or correct your record at any time. Because Points of Origin, PLLC participates directly with certain insurance plans and submits claims electronically, your medical records are subject to the provisions of the HIPAA regulations, regarding allowable releases of information or specific mechanisms of privacy protection. We are committed to protecting your privacy. Your records are confidential and we will not disclose your record to others unless you specifically direct us to do so, or unless the law authorizes or compels us to do so. If you have any questions or concerns please let us know.
Initial_____ *I acknowledge that I have been offered a copy of the HIPAA Notice of Privacy Practices for Points of Origin, PLLC to read and/or take home. (A copy is posted on our website and in the Points of Origin Office Policies manual if you wish to read it at any time. Please feel free to ask any questions about any of our policies.)*

I have read, I understand, and I agree to the above information and this policy statement.

_____ _____ _____
Signature **Printed Name** **Date**