Blue Cross and Blue Shield Financial Disclosure

As your Acupuncturist, I want to provide you with the best care possible. While your policy covers some acupuncture services, there may be others that I feel would help the treatment of your condition and maintenance of good health, but are not covered by your health insurance coverage. If you agree to receive these services, and they are later determined to not be eligible for reimbursement through your health plan policy, your signature on this form signifies your agreement to pay for them in full. While you may choose to not obtain these services, I want to reassure you that I will only recommend care that I believe will benefit your health. Federal Policy coverage notice: under federal law Licensed Acupuncturist are not recognized in policies covered under federal laws and rules and may not be a covered provider and services provided at this clinic would not be covered.

Acupuncture services typically covered by Blue Cross and Blue Shield state policies include:

1. Chronic Pain as defined as duration of at least six months when the following criteria have been met, prior to beginning of acupuncture treatment
   - A comprehensive history and physical evaluation of the patient has been completed to document etiology of the pain and
   - Conservative forms of multidisciplinary therapy (for example, pharmacologic therapy, physical therapy, psychotherapy) have been tried and have failed to alleviate the pain.
2. Prevention and treatment of nausea associated with surgery, chemotherapy or pregnancy.

I have read and fully understand all of the information above.
Printed Name (First, Middle, Last): ___________________________
Signature: ____ **Date**: ____/____/____

Benefits Assignment
I hereby authorize the assignment of benefits (payments) directly to Bonnie M. Abel Bolash, M.Ac., L.Ac. or legal representative for all my insurance claims related to services received. I agree to pay any and all charges that exceed, or are not covered by my insurance. I understand that co-payments, deductibles, and non-covered services are due in full at the time of service. I also give permission to release any medical records related to the service dates submitted or other records requested to substantiate the claim for reimbursement. In the event that services that were covered were then at a later date determined to not be a covered service I agree to pay for those services rendered.

Signature of Responsible Party: ____________________________ **Date**: ____/____/____

BCBS Policy Holder Name:_________________________________**DOB:** ____/____/____

BCBS Policy Number:__________________________**Group:**_________________________

Do Not Bill my Insurance:____
Signature Date