Kristen Swegles, MTCM, LAc. | 411 East Canon Perdido Suite 18
kristenswegles@gmail.com | kristenswegles.com | (831) 359-7779

Notice and Authorization for Insurance Billing

I, ____________________________________ *(print name),* do hereby give full permission and authorize Kristen Swegles LAc. to bill my insurance for services rendered by Kristen Swegles LAc. I also agree to have any checks or payment made by said insurance company to be payable and deliverable to:

Kristen Swegles LAc.

411 East Canon Perdido Suite 18

Santa Barbara Ca 93101

As a courtesy, my insurance will be billed directly by Kristen Swegles LAc. When possible, Kristen Swegles LAc. will call my insurance to verify my benefits, although benefits quoted by my insurance company are not a guarantee of payment. I am responsible for knowing the benefits my insurance policy covers. Payments will be due at the time of service for any non-covered services, deductibles or co-pays.

I understand if I do not have insurance coverage, I will receive a cash discount. If I do have insurance that covers acupuncture treatment or other modalities, Kristen Swegles LAc. will bill my insurance for me at the full insurance fee rate. **I understand a full fee rate for services rendered is available upon request. I will be required to pay my insurance policies stated copay or coinsurance fee if required by my insurance, and/or the difference of the full insurance reimbursement and cash based fees.**

I understand the aforementioned office fees, insurance and billing policy. If my insurance is billed by this office, my billing statement will show "signature on file."

Please check one of the following:

____ I authorize Kristen Swegles LAc. to bill my insurance.

____ I choose not to have my insurance billed for me and will pay cash or credit card for my treatments at the time of service.

____   __________________________

Signature   Date