**Sharon Pruss, L.Ac.**

**310-621-4553**

***Offices in Torrance and Huntington Beach***

**2019 OFFICE POLICIES**

Email: artoftcm@yahoo.com

**OFFICE HOURS**

In addition to the hours posted, we do see patients *by appointment only*, and we also are available to care for you *at home* if necessary.

**HERBS & SUPPLEMENTS**

Herbs and supplements are custom ordered exclusively for you, and must be **prepaid** in advance. There is no return/refund on any of these items.

**LAB TESTS**

You will be given a lab kit to either do a saliva, stool or blood test. Payment for all lab testing is handled between the patient and the lab. We do not accept payment from you directly. **We do charge a $25 processing fee for each lab test ordered as well as an “interpretation fee” of $150 per hour.**

**PAYMENT**

We accept checks, cash, HSA and credit cards. Payment is expected at the time of your visit.

**BILLING INSURANCE**

We bill insurance as a courtesy and only can bill PPOs, EPOs and similar (no HMOs). We are in-network with Anthem Blue Cross, Tivity, Humana, United Healthcare, and the VA Choice Program. We are out-of-network with all other insurance companies.

*Note: In many cases your initial visit fee may not be covered by your insurance and will be required at the time of service. If your insurance does cover it, your account will be credited the difference upon reimbursement.*

We anticipate timely reimbursement of your claims submitted (30 days or less). In the event that the reimbursement takes longer than 30 days, we request that the patient call their insurance plan to try to expedite the payment. After 30 days, the patient is ultimately responsible for payment and will be charged for any visits which have not been reimbursed by insurance. Further, if the insurance reimbursement is inadequate, we reserve the right to further request the balance from the patient.

**CANCELLATIONS**

Cancellations and rescheduling of appointments must be done at least 24 hours in advance. You will be charged $100 for the initial visit and $55 for the follow-up visit for any cancellations made less than 24 hours before the scheduled appointment and for no-shows. We appreciate your understanding and courtesy with regards to missed appointments as this time has been set aside exclusively for you.

A $35.00 fee will be charged for any returned checks. Returned checks must be replaced by a secured form of payment (credit card or cash). Payment is due when services are rendered.

By signing below, you authorize the release of any information necessary to your insurance company in order to process your claim.

**I have read and understand the above terms and agree to all patient policies.**

**Patient or Guardian’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**