FINANCIAL POLICY

Tang Traditional Acupuncture & Chinese Medicine LLC

DBA: Tang Acupuncture

Address: 3921 Sunset Ridge Rd, Suite 302, Raleigh, NC 27607

Phone: (919) 503-3558

Website: https://tangacupuncture.com

FINANCIAL POLICY

Thank you for choosing Tang Acupuncture for your healthcare needs. The following financial policy is intended to ensure clear communication regarding payment responsibilities and insurance benefits. Please read carefully and sign below.

Insurance Benefits

As a courtesy, our office may verify your insurance benefits and submit claims on your behalf. However, insurance coverage information provided before treatment is only an estimate and does not guarantee payment.

The patient is ultimately responsible for all charges not covered by insurance, including but not limited to:

- Deductibles
- Copayments
- Coinsurance
- Non-covered services
- Services determined by the insurance company to be medically unnecessary
- Claims denied due to benefit limitations or policy exclusions

Insurance companies make final determinations regarding coverage and reimbursement.

Payment at Time of Service

Payment is due at the time services are rendered unless other arrangements have been made.

Accepted forms of payment include:

- Major credit and debit cards
- HSA/FSA cards
- Apple Pay

- Google Pay
- Jane Payments
- Zelle
- Cash

Outstanding balances may be collected prior to scheduling future appointments.

Self-Pay Services

Patients without insurance coverage or who choose not to use their health insurance are responsible for payment in full at the time services are rendered.

Self-pay fee schedules are available upon request and are provided prior to services when applicable.

Good Faith Estimate (No Surprises Act)

Patients who are uninsured or who choose not to use their health insurance have the right to receive a Good Faith Estimate of expected charges under applicable federal law.

The estimate reflects reasonably expected charges based on the information available at the time it is prepared and is not a binding contract or guarantee of final costs.

Actual charges may differ if additional medically necessary services are provided or if the patient's clinical condition requires modification of the treatment plan.

Patients may request a Good Faith Estimate at least 1 business day before their scheduled appointment by contacting our office at (919) 503-3558. If your final billed amount exceeds your Good Faith Estimate by $400 or more, you have the right to initiate a dispute through the federal Patient-Provider Dispute Resolution process.

Insurance Claims

Our office may submit insurance claims to participating or out-of-network insurance plans as a courtesy to the patient.

Submission of claims does not guarantee payment or reimbursement by the insurance carrier.

If a claim is delayed, denied, or not processed within a reasonable timeframe, the patient may be responsible for the outstanding balance until resolution is obtained.

Patients agree to provide any information reasonably required to facilitate insurance claim processing, coordination of benefits, or medical necessity review.

Returned Payments

Returned checks or declined payments may be subject to additional fees permitted by law.

Collection of Outstanding Balances

Accounts with unpaid balances may receive statements, reminder calls, emails, or text messages.

Balances remaining unpaid after reasonable collection efforts may be referred to a collection agency or attorney. The patient agrees to be responsible for any reasonable costs associated with collection efforts as permitted by law.

Refund Policy

Refunds for overpayments will be processed promptly.

Professional services that have already been rendered are non-refundable.

Unused prepaid services, if any, may be refunded according to applicable laws and office policies.

No Guarantee of Insurance Payment

Insurance benefits quoted by our office are not guarantees of payment. Coverage determinations are made solely by your insurance company.

The patient acknowledges financial responsibility for services provided regardless of insurance reimbursement.

PATIENT ACKNOWLEDGMENT

☐ I have read, understand, and agree to the Financial Policy of Tang Acupuncture. I understand that I am financially responsible for charges incurred for services provided.

Patient Signature: Date:

*If signed by a parent, legal guardian, or personal representative:

□ Parent of Minor Child □ Legal Guardian □ Personal Representative

□ Healthcare Power of Attorney □ Other：

Representative Name: Date: