SNOW BLOSSOM ACUPUNCTURE LLC
WELLNESS & FLOAT CENTER

Self-Pay Agreement

Patient Name: _____

Date of Birth: _____

Rendering Provider:

- ☐ Seth Wood
- ☐ Kristen Wood
- ☐ Kimberly Pruetting
- ☐ Shannon Gularte
- ☐ Mary Ann Gates

I, _____, the undersigned patient,
(Patient)
understand and agree to the following:

1. I am not currently covered by any insurance plan(s) OR my insurance does not have benefits for these services.

2. I have received copies of the Time-of-Service fee schedule and the rates quoted to me for my service are as follows:

☐ Acupuncture (Private Room)
Initial Visit: $235.00
Follow-up Visits: $150.00

☐ Cupping
Initial Visit: $75.00
Follow-up Visits: $60.00

☐ Community Acupuncture
Initial Visit: $70.00
Follow-up Visits: $50.00

☐ Battlefield Acupuncture
Initial Visit: $70.00
Follow-up Visits: $50.00

☐ Massage Therapy
30- Minutes: $65.00
60- Minutes: $135.00
90- Minutes: $190.00

3. I understand that no forms will be produced now, or in the future, for me to submit to insurance for billing; therefore, I agree to not submit claims to any insurance for any of the selected services rendered.

4. I have read this Election to Self-Pay for Services form and have had the opportunity to ask any questions I may have about the form. Any questions I may have had about this form have been answered to my satisfaction.

Patient Signature: _____ Date: _____