



Sage Wellness Center

601 South B Street – Suite B

San Mateo, CA 94401

(650) 343-7899

Fax: (650) 458-9209

www.sagewellnesscenter.org

SAGE WELLNESS CENTER INSURANCE POLICIES

We are happy to work with your insurance if it is an approved insurance company with our insurance billing service. We currently accept most PPO insurance plans *except* Blue Cross and Blue Shield. We will check coverage and let you know before any services are received. Please call ahead of your first appointment to see if we accept your particular insurance. Often times it takes several days to confirm coverage so please give enough time so you are fully informed if and what will be covered.

Office Rates: We have our office rate which is \$165 for first visit and \$95 per follow up appointments. This is the amount that will be billed to your insurance for acupuncture. Other modalities used may be extra. If you do not use insurance and pay in full at time of your visit, you will receive our discounted cash fee of \$150 for first visit and \$85 for follow-up visits.

Be signing below you agree to pay any portion of the office rate that is not covered by your insurance. We will keep your credit card information on file to secure payment for any portion of your session the insurance companies may not cover. We will not charge your credit card, unless your unpaid balance has gone delinquent over 90 days. By signing below you accept responsibility for any remaining balance. We will inform you once we receive payment from your insurance company and clearly detail any remaining balance (approx 3-4 weeks from first appointment).

Credit Card _____ Sec code _____ Billing Zip Code _____

Patients Signature _____

Date _____

Thank you very much. We look forward to working with you.

ABP Insurance Verification Form	Provider : _____
	FAX TO: 619-334-3158
Patient Name: _____	Patient DOB: _____ Insured ID#: _____
Patient Address: _____	City _____ State _____ Zip _____
Insured's Name: _____	Group# _____ Ins. Co Phone#: _____
Ins. Co. Name: _____	
Ins. Co. Claims Address: _____	

GENERAL INFORMATION

Date: _____
 Person Spoke To: _____
 Effective Date: _____
 Plan Type: _____

CALENDAR (Jan-Dec) / ANNUAL Plan
 If annual plan, from _____ to _____

IN / OUT of Network Benefits

DEDUCTIBLE INFORMATION

Individual Deduct \$ _____ Amt Met \$ _____
 Family Deduct \$ _____ Amt Met \$ _____
 Deduct Combined In & Out of Network YES / NO

PROCEDURES COVERED INFORMATION

Exams Covered? YES / NO % Paid _____
 Initial Exams Only? YES / NO
 97112 Neuromuscular Reeducation YES / NO
 97140 Manual Therapy YES / NO
 97010 Hot/Cold Packs YES / NO
 97026 Estimulation YES / NO
 97124 Massage Therapy YES / NO

VISIT LIMIT INFORMATION

Visit Maximum _____ Visits Remaining _____
 Combined With _____
 Combined In & Out of Network? YES / NO
 When meeting deduct, are max # visits used? YES / NO

 Annual \$ Max _____ Amt used \$ _____

PLAN PAYMENT INFORMATION

% Paid _____ OR Visit \$ Max _____

 National Account? YES / NO
 If YES, payment may go to patient.

OUT OF POCKET INFORMATION

Max out of pocket \$ _____ Amount met \$ _____
 Once met claims pay at 100% YES / NO

REFERRAL INFORMATION

Need a Dr.'s referral? YES / NO
 Rx needed? YES / NO
 Auth Required? YES / NO PH# _____
 Additional Visits PH# _____
 Submit clinical treatment form after _____ visit.

NOTES: _____

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