Shirai Clinic, LLC
3024 SE 59th Ave
Portland, OR 97206

Kumiko Shirai, MSOM, LAc
info@kumikoshirai.com
Phone: (541) 729- 1164

Financial Agreements

Dear New Patient,

Welcome to Shirai Clinic, LLC! As your healthcare provider, I look forward to applying my expertise for your healthcare needs. I strongly encourage and welcome your commitment to achieving a better health and quality of life through your cooperation with me. At all times, please provide me with your questions and valuable feedback.

Please read and initial the following items:

____ Payment for all services and medicinary items is due in full at the time of visit. The clinic accepts cash, personal checks and most major credit and debit cards. There will be a charge of $30 for every returned check.

____ You will be charged a Missed Appointment fee of $50 for any missed appointment or late cancellation (less than 24 hours notice).

____ Full payment is expected at time of service. In the case that you are using health or auto insurance to pay for a portion of your care, arrangements may be made to omit payment to await reimbursement. Please fill out the Insurance Eligibility and Benefits Information on the back side of this form. By signing below, you accept full financial responsibility for any outstanding charges that are not covered by your insurance and authorize release of your medical records relating to the claim for benefits submitted.

____ I have read and understood the above stated policies of Shirai Clinic, LLC and will comply with them in all respects.

_____
Your signature *(parent or guardian if minor)*

_____ _____
Print name *(parent or guardian if minor & patient name)* Date

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Insurance Eligibility and Benefits Information

Shirai Clinic, LLC accepts some insurance plans if acupuncture is a covered benefit under your plan. In order to verify your benefits with your insurance company, please provide us information below and keep me to date with any changes to your insurance plan.

Your Name: _____ Date of Birth: _____

Your Phone #: _____ Policy/ID #: _____

Insurance Company: _____ Group #: _____

Insurance Phone #: _____

If you are not the primary policy holder, please fill out the following information.

Name of Primary Policy Holder (Guarantor): _____

Your relationship to Guarantor: _____ Guarantor's DOB: _____

If your acupuncture treatment is related to a car accident please fill out the following information:

Adjuster: _____ Adjuster's Phone #: _____

Date of Accident (DOI): _____ Claim #: _____