CHIROPRACTIC INSURANCE POLICY

Our policy is set up to utilize direct payment from insurance companies. This is done as a service to our patients and there is no charge for this service. However, it is important that you (the PATIENT) understand that health and accident insurance policies are an arrangement between you and your insurance company. You are responsible for all service charges incurred in our office. We expect payment in full when the services are rendered until your insurance coverage has been verified.

Patient Name: _____

Please fill out this form and return it to our office at your next visit. HERE IS WHAT YOU DO TO VERIFY FOR CHIROPRACTIC CARE.

DATE you called your insurance company ____/____/____
NAME of person who gave you information _____

1. CALL your insurance company and ask the following questions:
   a. Does my policy cover Chiropractic: ❑ Yes ❑ No
      If yes, are there any limits to my coverage? ❑ Yes ❑ No
      What are those limits? (Be as specific as possible): _____
      _____
      Will they cover cervical pillows? ❑ Yes ❑ No
      Nutritional Supplements? ❑ Yes ❑ No
      Structural Supports? ❑ Yes ❑ No
      Is there any limit to the number of visits allowable? _____
   b. Does my policy cover X-rays? ❑ Yes ❑ No
      If yes, what % _____
   c. Does my policy cover massage therapy? ❑ Yes ❑ No
   d. What is the DEDUCTIBLE? _____ Is that yearly? ❑ Yes ❑ No
      Has it been paid? ❑ Yes ❑ No If yes, how much? $_____
      Is there a carry-over? ❑ Yes ❑ No Is there a family deductible? ❑ Yes ❑ No
   e. What Percentage of my bills will my policy cover? _____
   f. What is the Effective Date of my policy? ____/____/____
   g. Can Benefits Be Assigned to my Chiropractor's Office? ❑ Yes ❑ No
   h. What is the address of the office where the claims are sent? _____
      _____
   i. To Whose Attention is claim sent? _____
   j. PHONE NUMBER of insurance company ____-____-____
   k. POLICY NUMBER _____
      Individual Policy? ❑ Yes ❑ No Group Policy? ❑ Yes ❑ No
      Name of policy under? _____
   l. Please check on that applies to your case:
      ❑ Major Medical ❑ Personal Injury ❑ Industrial Accident/Worker's Compensation

2. Obtain an Insurance Form from your agent or place of employment. Fill in the required Information. Where applicable have your employer fill in the indicated section(s). Then bring the form to our office. This questionnaire and your insurance form should be brought to our office within two weeks of your first visit. Once your coverage is confirmed we will accept payment directly from the insurance company.

3. If you have any questions or problems, please direct them to the Case Manger.

____/____/____	_____	_____
Date	Time	Patient's Signature