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 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 will expect payment in full when the services are rendered **until** your insurance coverage has been verified.

Patient's Name:____

Please fill out this form and return it to our office at your next visit. HERE IS WHAT YOU DO TO VERIFY COVERAGE 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 limits to my coverage? _______Yes _______No
      What are those limits? (Be as specific as possible):____________________
      ____
      ____
   b. What is the deductible?________________________________
      Has it been met?_____Yes _____No If no, how much has been met? ____________
      Is there a carry over? ____Yes ____No Is there a family deductible? ____Yes____No
   c. What percentage of my bills will my policy cover? ____________________
      OR is there a pre-set co-payment? How much? $________________
      If there is a pre-set co-payment, does that include ALL services ________Yes ________No
      OR is there a separate co-payment for other services: Exam $____________
      X-ray $____________
      Physical Therapy $____________
      Manipulation $____________
   d. Does my policy cover:
      Durable medical equipment? ____Yes ____No
   e. What is the effective date of my policy? ________________________
   f. Can benefits be assigned to my Dr.'s office? ____________________
   g. What is the address of the office where claims are to be sent?
      Name of Company:________________________________
      Address:____
      ____
      To whose attention are the claim sent? ____________________
      Phone number of insurance company: ____________________
   h. Policy # ____________________ Group # ____________________
      Plan # ____________________ ID # ____________________

2. 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 office staff.

______________________________ ______________________________
Date Time Patient's Signature