

INSURANCE VERIFICATION FORM

Your Name (printed): _____ Date: _____

Please have the following information when calling your insurance company:

- 1) Insurance company's phone number (on the back of your card): _____
- 2) Policy holders name: _____ Date of Birth: _____

Please obtain and verify the following information. We cannot process your claim without this information. Thank you.

1. Ask for the name of the person giving you this information: _____
2. Ask if you have chiropractic coverage for "*out of network*" providers. If yes, please continue to verify type and amount of coverage.
 - A. What is the yearly deductible: Per Person: _____ Per Family: _____
 - B. How much of the deductible has been met this year: _____
 - C. What is your co-pay: _____
 - D. Is there a limit to the number of visits: _____ How many: _____
 - E. What is the effective date of your policy: _____
 - F. Policy holder's employer: _____ ID# _____
Group # (if applicable to your policy): _____

G. Name and address of the insurance office where the claims are sent:

Thank you for obtaining and verifying this information with your insurance company. We expect they will reimburse your account as noted above. If there is a discrepancy, we will notify you immediately.

ACTIVE HEALTH CHIROPRACTIC

INSURANCE INFORMATION

Insurance is a contract between the insured (patient) and the insurance company. The following information will help you to understand how insurance can be utilized in our office and the details regarding your participation in the process.

We have learned, over the past several years that the insured (patient) is the only one to whom the insurance company **must** give accurate information. It is for that reason that we ask you, the insured (patient), to complete an "Insurance Verification Form", (as explained below).

Please read the following information to clarify insurance procedures.

Insurance companies, such as HMO's, PPO's and others, create their own guidelines and are not required to cover chiropractic services. If chiropractic services **are covered**, the amount and type of reimbursement varies according to the policy that has been purchased by you or your employer.

If you have an insurance plan that reimburses for chiropractic care in this office, you **must verify** the type and amount of coverage before you can submit claims. On the reverse side of this form is an "**Insurance Verification Form**" that will assist you in obtaining all the vital information needed for you to be able to submit bills to your insurance. Until we receive this information, your account must be on a cash basis. Please understand that you are responsible to pay for all services not covered by your insurance company (including deductibles, co-payments and any other balances not reimbursed by the insurer.)

I HAVE READ, UNDERSTAND AND AGREE TO COMPLETE ALL FORMS NECESSARY. I UNDERSTAND THAT I AM RESPONSIBLE TO PAY FOR SERVICES RENDERED TO ME, BUT THAT ACTIVE HEALTH CHIROPRACTIC WILL PROVIDE ME WITH THE PAPERWORK NEEDED SO I CAN SUBMIT TO MY INSURANCE.

Patient Name Printed: _____

Patient Signature: _____ **Date:** _____