Notice to Our Patients with Insurance Coverage

As a courtesy to you, we will call your insurance and ask them what, if any, chiropractic coverage you may have at our office. Please be advised that there have been instances when the insurance company did **not** give us correct or complete information. One problem has been that we were not informed that your company requires a referral from your doctor before your chiropractic coverage is allowed. To avoid any problems that may arise, **we request that you also call your insurance and verify your coverage**.

We require that this form be completed before we can bill your insurance. If it is discovered that your insurance company has given us incorrect information, and that you do not have coverage, you are responsible for paying for your care.

Have the following information available when you call (on insurance card):

Subscriber's name (who owns the policy?) & birthdate__________________________
Subscriber's employer___________________Patient's name_____________________
Patient's relationship to subscriber__________________Patient's birthdate__________
Plan name___________________ID#________________Plan/group #______________
Name and phone number of insurance company_________________________________
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Please ask the following questions to verify all aspects of your insurance coverage:

1. Date__________ Name of person you spoke to_______________________________
2. Does my policy cover Chiropractic care? Yes______No_________
   Do you require that I see a Dr. in network? Yes______No_________
   If yes: Is Dr. Laura in network? Yes______No_________
   Dr. Bruce? Yes______No__________
   If no: do you pay anything on non-network claims? ___________________________
3. Is a referral required from my medical doctor? Yes______No_________
4. Do I have a co-insurance?________ What percentage to I pay?___________________
5. Do I have a co-pay? __________ What is it?__________________________________
6. Do I have a deductible?________ What is it?_________________
   How much have I met this year?____
7. What is the effective date of my policy?______________________________________
8. Is there a limit to the number of visits I can make to my Dr.?_____________________
9. Does my policy cover ultrasound or physical therapy? Yes___ No____
10. Does it cover massage therapy? Yes___ No____ How much?_______________
    Does it require that the massage be done by the Dr., or a CMT?____________
    Does it cover massage and chiropractic done on the same visit? Yes____No_____
11. Does my policy cover any durable medical equipment? Yes______No_________
12. Are there any other limits to my coverage? ______________________________
13. What is the address and phone # of the office to which claims are sent? ___________

Signature____ Date__________________