Chiropractic Associates of Port Colborne/ORI Extended Insurance Coverage Form

To assist us in minimizing your out-of-pocket costs, please provide our office with the following insurance information:

Date:_____

Surname:_____

First name:_____

Do you or your spouse currently have extended health coverage for chiropractic/massage therapy or physiotherapy?

❑ Yes ❑ No

If yes,

Insurance Company Name:_____

Policy Number:_____

Employer:_____

	Yearly Coverage Allowance	Per Visit Amount	Deductible
Chiropractic:			
Massage:			
Physiotherapy:			
Acupuncture:			
Orthotics:			

Fiscal year ❑

Or Calendar Year ❑ coverage?