PARASCAK FAMILY CHIROPRACTIC

EXTENDED HEALTH CARE INSURANCE FORM

PLEASE FILL OUT THIS FORM AND RETURN IT TO OUR OFFICE ON YOUR NEXT VISIT.

1. PATIENT'S NAME: _____

Insurance Company: _____

Name of the policy holder: _____ Date of Birth (yyyy/mm/dd): _____

Group/Contract/Policy #: _____ I.D.# _____

2. CALL YOUR INSURANCE COMPANY

Date you called Insurance Company: _____

Name and # of person who gave you information: _____

3. ASK THE FOLLOWING QUESTIONS:

1. Does my policy cover chiropractic care? Yes ☐ No ☐ (If no, then you do not have to complete the rest of this form)
2. Does my policy allow for my chiropractor, Dr. Brad Parascak, to direct bill on my behalf ***OR*** am I required to pay the office and submit statements on my own? Direct Bill ***OR*** Pay and Submit (circle one)
3. What is the amount of coverage allowed per person per benefit year? $_____
4. How much coverage is remaining for the current benefit year? _____
5. Is my amount of coverage: Exclusively for chiropractic ***OR*** is it included with a group of services? (Circle one)
6. What is my benefit year? (Ex. Jan. 1 – Dec. 31) _____
7. Is there a maximum amount per visit? _____ (Is it a dollar amount or a percentage amount?)
8. Do I have to pay a deductible? No ☐ Yes ☐ If yes: How much is it? _____
   Is that yearly? Yes ☐ No ☐ Has it been paid? Yes ☐ No ☐
9. Does my policy cover X-rays at a chiropractic office? No ☐ Yes ☐ If Yes, is the X-ray cost included in the amount of coverage ***OR*** is it in addition to the amount of coverage? What is the $ amount allowed for the X-ray? _____

4. FURTHER INFORMATION:

1. Are you covered by any other insurance plan? No ☐ Yes ☐ If yes, please fill out another form.
2. Do you have dependents/spouse/children who are covered by this insurance plan? Yes ☐ No ☐

Name: _____ DOB: (y/m/d) _____ ID#: _____

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