PARASCAK FAMILY CHIROPRACTIC

EXTENDED HEALTH CARE INSURANCE FORM

PATIENT'S NAME: _____

Insurance Company: _____

Policy Holder: _____ Date of Birth (yyyy/mm/dd): _____

Group/Contract/Policy #: _____ ID #: _____

CALL YOUR INSURANCE COMPANY:

Date you called your Insurance Company: _____

Number you called and who you spoke to: _____

ASK THE FOLLOWING QUESTIONS:

1. Does my policy cover chiropractic care? □ Yes □ No (if no, you do not have to complete this form)
2. Does my policy allow for my chiropractor, Dr. Brad Parascak, to:
   □ direct bill on my behalf OR □ I am required to pay and submit on my own
3. If directing billing on your behalf, does the payment go to:
   □ The servicing provider OR □ The insured member
4. What is the benefit year for my policy? (ex. Jan. 1 – Dec. 31) _____
5. What is the amount of coverage allowed per person per benefit year? _____
6. How much coverage is remaining for the current benefit year? _____
7. Is there a maximum per visit? □ No □ Yes – How much? _____
8. Is my amount of coverage:
   □ exclusively for chiropractic OR □ included with a group of services
9. Does my policy cover chiropractic x-rays? □ No □ Yes
10. If Yes, is there a maximum cost for those x-rays? □ No □ Yes – How much? _____
    and is that amount:
    □ included in the amount of coverage OR □ in addition to the amount of coverage
11. Do I have to pay a deductible? □ No □ Yes
    If Yes, How much? _____ Has it been paid? □ Yes □ No
    Is it Yearly? □ Yes □ No

FURTHER INFORMATION:

1. Are you covered by any other insurance plan? □ No □ Yes (if yes, please fill out another form)
2. Please list any dependents (ex. spouse, children) that are covered by your policy:

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

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