INSURANCE VERIFICATION

It is your responsibility to verify your own insurance coverage for chiropractic care.
Until you provide us with the following information, you will be charged full price
for all services you receive from Van Every Family Chiropractic Center.

Personal Info

Patient Name:_____ Date I called insurance company: _____

I Spoke to: _____ Is there a Reference #? : _____

How does my Policy year run? (ie Jan-Dec? July-June?): _____

Do I need a referral from a primary care physician? YES or NO

Do I have a **Deductible**? YES or NO How much is it? _____ How much has already been met? _____

Is there a maximum amount that your insurance will contribute to chiropractic care? YES or NO How much? _____

Office visit/exams (Exams - code 99202)

Does insurance cover Office Visits—exams? YES or NO How often? _____

How much do I pay while still paying off my deductible?_____

What is my Copay after my deductible is met? _____

Office visit/re-exams (Re-Exams - code 99212)

Does insurance cover Office Visits—re-exams? YES or NO How often? How long after initial exam? _____

How much do I pay while still paying off my deductible?_____

What is my Copay after my deductible is met? _____

Adjustments (Manipulation - code 98941)

How many Manipulations (adjustments) does insurance contribute to? _____

Have I used visits at another chiropractor? YES or NO If so, how many were used? _____

How much do I pay while still paying off my deductible?_____

What is my Copay after my deductible is met? _____

Massages (code 97124) (1 unit = 15 minutes, so 1 hour massage is 4 units)

Does my insurance contribute to massages? YES NO

How many are allowed? _____ What is my Copay for massages?_____

I understand that this information which was provided by my insurance company, may or may not be accurate, is **NOT** a guarantee of payment, and may change at **ANYTIME.**
I agree to be responsible for payment of all services rendered (on my or my dependents behalf) **DENIED or NOT** covered by my insurance company.

Patient Name _____

Patient Signature_____

Date_____