FAIRBANKS
FAMILY WELLNESS

Patient Insurance Coverage Details -

Please call your insurance and ask them the coverage for the below services that are offered at our clinic.

Patient Name: _____ DOB: _____

Patient Address: _____
Patient Phone Number: _____
Name of Insured: _____ DOB: _____
(If different than patient)

Name of Insurance: _____
Policy ID: _____ Group #: _____

When do benefits start over and deductible is due. (circle one)
Calendar year = Jan 1st - Dec 31st
Plan/Contract yr = Apr 1st - March 31st or June 1st - July 31st etc...

Benefits	$ amount or % due at visit
Deductible Family -	_____
Deductible Individual -	_____
OOP (Out of Pocket) Family -	_____
OOP Individual -	_____
ND/MD Office Visit -	_____
Annual/Wellness Visit -	_____
Chiropractic -	_____ # of Chiro Visits Allowed - _____
Counseling -	_____
BioFeedback (CPT 90901) -	_____
Acupuncture -	_____ # of Acu Visits Allowed - _____

Massage - _____

(LMT or Chiropractic) **Circle one**.

# of Massage Visits Allowed - _____

Physical Therapy - _____

# of Physical Therapy Visits Allowed - _____

By knowing the coverage that is allowed from your insurance for the services we offer, we will collect the amount that is due per insurance at the time of your visit. As a courtesy we will bill your insurance for services rendered. Insurance is not a guarantee of payment and you are responsible for any leftover amount due on your account. I acknowledge and agree with this statement. This form is good for 1 year from the date signed.

Signature:

_____ **Date:** _____