# Insurance Questionnaire

***The following questions are necessary so that we may properly file your insurance for you. These questions are taken directly from the insurance form that we must fill out and file for you. Please answer as fully as possible.***

1. Type of insurance: Medicare____Medicaid____Champus___CampVA____
   Group Health Plan____ Other____Insured's ID Number_____
2. Patient Name:_____
3. Insured's Name (as it appears on the insurance card):_____
4. Patient's Address:_____
   City_____State_____ Zip_____Tel #_____
5. Insured's Address (if same as patient put "same"):_____
   City_____State_____ Zip_____Tel #_____
6. Patient Status (circle one): Single Married Other Employed Full-time Student Part-time Student
7. Other Insured's Name (if applicable):_____
   Other Insured's Policy or Group Number:_____
   Other Insured's Date of Birth:_____ Male_____Female_____
   Employer's Name or School Name:_____
   Insurance Plan Name or Program Name:_____
8. Is the condition we are treating related to current or previous employment? Yes____ No____
9. Is the condition we are treating related to an auto accident? Yes____ No____
10. Is the condition we are treating related to another type of accident? Yes ____ No____
11. Insured's Policy Group or FECA Number:_____
    Insured's Date of Birth:_____Male_____Female_____
    Employer Name or School Name:_____
    Insurance Plan Name or Program Name:_____
12. Is there another health benefit plan? Yes____ No____

**Patient's or Authorized Person's Signature:** I authorize the release of any medical or other information necessary to process my insurance claim. This is to serve as a long-term authorization card.

Signed: _____Date:_____

**Insured's or Authorized Person's Signature:** I authorize payment of medical benefits to for the services described on the insurance form. This authorization is to apply to all occasions of service until it is revoked in writing. I agree to pay for services not covered by insurance and understand that I am ultimately responsible for payment in full at this office.

Signed: _____Date:_____

**MEDICARE ONLY**

*All doctors have been instructed to ask the following questions of all Medicare patients.*

1. Do you or your spouse work for a company that provides you with health insurance? Yes___ No___
2. Are you entitled to Medicare because of End Stage Renal Disease? Yes___ No___
3. Is the illness or injury the result of an accident or illness that occurred at work? Yes___ No___
4. Is this illness or injury the result of an accident or other injury? Yes___No___
5. Has the treatment for this accident or illness been authorized by the Veteran's Administration? Yes__ No__
6. Are you entitled to any benefits under the Federal Black Lung Program? Yes___ No___
7. Do you have a Medicare Medigap Policy? Yes___ No___Name of Company_____
8. Do you have a Medicare Supplement Policy? (Policy provided by employer you retired from)? Yes___ No___

# Advanced Health Chiropractic
# FINANCIAL POLICY

**CASH PATIENTS:** Patients without the benefit of chiropractic coverage on their insurance are **responsible to pay 100%** of their charges as services are rendered. If care becomes extensive, a **payment agreement** can be provided which will spell out a monthly amount. Your balance may **never exceed $250.00** at any time unless you have been **set UP** on a payment plan.

**GENERAL INSURANCE:** As a courtesy to you we will bill your insurance company and wait for payment. The insured is responsible for knowing their insurance benefit coverage. Every attempt will be made to determine an estimate of the insured's coverage, but because the insurance policy is a unique agreement between your employer and the insurance company, **we can make no guarantees**. **We cannot become involved in disputes between you and your insurance company** regarding coverage and/or policy benefit criteria, i.e. deductibles, non-covered services, coinsurance, coordination of benefits, pre-existing conditions or "reasonable and customary charges", etc., other than to supply factual information when necessary. Each guest is ultimately responsible for the timely payment of their account.

**Your obligation is to pay any and all deductibles and co-payments as you go**. **You are also responsible for any "non-covered" services. If your carrier has not paid a claim within 60 days of submission, you are responsible to take an active part in the recovery of your claim and after 90 days you will be responsible for payment in full for any outstanding balance. Remember, the care and services were provided to *you* and not your insurance company. You are responsible for all cost incurred in this office.**

**MEDICARE:** As a participating provider with Medicare, we will accept what Medicare approves for your adjustments. Please be aware that **Medicare covers only chiropractic adjustments**. Medicare does not pay for any other services performed at our office.

**WORKERS COMPENSATION**: It is your responsibility to provide all necessary billing information to this office within five working days of your initial visit. Failure to do so will make you a cash patient and payment in full will be required on day five. If you have retained an attorney, you are also further required to provide this office with all attorney information. If you are a Missouri Workers Compensation patient, the laws require you, in your state, to get your employer's approval to come to this office. Without this approval, Missouri Workers Compensation will not pay for your care.

**PERSONAL INJURY:** All patients involved in a personal injury, such as a motor vehicle accident, are required to provide all necessary billing information and attorney information to this office within 5 working days of your initial visit. Failure to do so will make you a cash patient and payment in full of any outstanding balance will be required on day five. If you have retained an attorney you will be asked to sign a lien to protect any outstanding balance in this office at the time of settlement. **Any outstanding balance not paid at the time of settlement is YOUR responsibility.**

**PATIENT SIGNATURE:** _____
**PRINTED NAME:** _____
**DATE:** _____