Thrive Chiropractic
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**PLEASE READ ALL THE FOLLOWING INFORMATION TO CLARIFY INSURANCE PROCEDURES.**

Insurance is a contract between the insured (practice member) and the insurance company. The following information will help you to understand how insurance can be utilized for services received in our office and the details regarding your participation in the process.

Insurance companies, such as HMO's, PPO's and others create their own guidelines and are not required to cover chiropractic services. If chiropractic services are covered, the amount and type of reimbursement varies according to the policy that has been purchased by you or your employer. You should utilize the “Chiropractic Insurance Verification Form” (on the following page) when you call your insurance company to inquire about your coverage.

If you have determined that your insurance will cover your care in our office, we will work with you to receive your entitled benefits by providing you with receipts for submission. Please understand that our office has a relationship with you, not your insurance company. Therefore, we do not accept assignment of benefits from any insurance carrier (their reimbursement will come directly to the policy holder) and we require direct payment at the time the service is rendered.

I HAVE READ, UNDERSTAND AND AGREE TO VERIFY MY INSURANCE BENEFITS FOR CHIROPRACTIC SERVICES RENDERED AT THRIVE CHIROPRACTIC IF I WISH TO SEEK REIMBURSEMENT. I ACKNOWLEDGE THAT HAVING INSURANCE DOES NOT MEAN THAT THE SERVICES PROVIDED AT THRIVE CHIROPRACTIC WILL BE REIMBURSED. I UNDERSTAND THAT THRIVE CHIROPRACTIC WILL TAKE THE NECESSARY STEPS TO HELP ME GET REIMBURSED, BUT THAT SAID CORPORATION WILL NOT ENTER INTO A DISPUTE WITH MY INSURANCE COMPANY OVER PAYMENT.

Practice Member's Name (printed): _____
Practice Member's Signature: _____ Date: _____

# CHIROPRACTIC INSURANCE VERIFICATION FORM

Our office is out-of-network with all insurance companies. Because of that we provide this sheet for you to verify your benefits so you can still utilize your insurance. You are personally responsible for all service charges incurred in our office and we expect payment in full when services are rendered. This page lists specific items you need to discuss with your insurance company regarding chiropractic care benefits. This should be used as a guideline to assist you in asking the right questions when speaking with your provider. We recommend you keep a copy of this sheet for your own records, but our office also requires a copy if you will be seeking reimbursement (we can copy it for you). Thrive Chiropractic, LLC does NOT accept assignment which means that you will receive money directly from your insurance company if or when they decide to reimburse you. We will not enter into a dispute with your insurance company over payment.

Practice Member's Name (printed): _____ Date of Birth: _____
Phone Number: _____

**Please have the following information ready when calling your insurance company:**

Policy Holder's Name (if different): _____ Policy Holder's Date of Birth: _____
Policy Holder's Address: _____
Policy Holder's Employer: _____

***CALL your insurance company and ask ALL of the following questions:**

Insurance company's phone number (on the back of card): _____ Date Called: _____
Reference # for the Call: _____ Spoke to (first and last name): _____

1. Does my policy cover **OUT-OF-NETWORK** chiropractic services? □Yes □No
   a) If yes, are there limits to my coverage? □Yes □No What are those limits? (get specific details)
   _____
   _____
   b) Is there a limit to the number of visits allowable? □Yes □No If yes, how many? _____
   c) Is there a dollar limit? □Yes □No If yes, how much? _____
   d) Does occupational or physical therapy count toward the chiropractic visit max? □Yes □No
   e) Are services limited by "Medical Necessity"? □Yes □No
   f) Do they cover Wellness or Maintenance Care? □Yes □No

2. What is the individual **DEDUCTIBLE**? _____ Is that yearly? □Yes □No
   a) Does the policy begin: □Calendar Year □Contract Year □Other _____
   b) Has some or all of it been paid? □Yes □No If yes, how much? _____
   c) Is there a FAMILY deductible? □Yes □No How much?_____
   d) Is there a carry-over? □Yes □No If yes, how much? _____
   e) Which chiropractic services will apply to the deductible? _____

3. What **percentage** of my bills will my policy cover? _____

4. What is the **effective date** of my policy? _____

5. What is the **address of the office** and name of person/office where the claims are sent? _____
_____

6. Individual policy? □Yes □No **Policy #** _____
   Group policy? □Yes □No **Group #** (if applicable) _____

7. Please **check the one that applies** to your case:
   a) □ Major medical
   b) □ Personal injury
   c) □ Auto accident
   d) □ Industrial accident/worker's compensation