

# ATTENTION PATIENTS

## For Your Information

We now have insurance verification forms to assist you in your call to your insurance company to determine your chiropractic coverage. Your insurance policy is an agreement between you and your insurance company, so it is to your advantage to contact them directly to discuss what benefits you may have.

All billing will be based on the explanation of benefits determined by your insurance company. If there is a discrepancy as far as billing, the patient will be responsible for contacting the insurance company to resolve the matter.

Payment is expected at time of service. Cash, Check, Visa, MasterCard and Discover payments are available. Payment plans are also obtainable if necessary.

We value your patronage and we will continue to do everything we can to make our commitment to your health of highest importance.

## Thank-you

Please fill out the form on the following pages and bring it to your office visit.

# New Hanover Chiropractic Rehabilitation Center

## Patient Insurance Verification Form

**New Hanover Chiropractic Rehab Center**; 1810 Swamp Pike Suite 100, Gilbertsville, PA 19525;  
610-327-3363; Fax: 610-327-9829

Mark L. Halteman, D.C., JoEllen K. Hoobin, D.C., Frederick J. Sylvester, D.C., Karen vanEverdingen, D.C.  
Tax Identification Number: 23-3024061

Insurance Co: \_\_\_\_\_ ID#: \_\_\_\_\_

Effective date of policy: \_\_\_\_\_ Insured: \_\_\_\_\_

Date called: \_\_\_\_\_ Spoke with: \_\_\_\_\_ Phone # called: \_\_\_\_\_

Is my chiropractor in-network? YES NO

Do I have a co-pay for:

Office visit: \$ \_\_\_\_\_

Manipulation: \$ \_\_\_\_\_

Chiropractic Rehab: \$ \_\_\_\_\_

Do I have to pay multiple co-pays in one visit when more than one procedure is performed? YES NO

Are the following codes eligible for coverage? 97110 97116 97112 97750 97530 97014 **97535 (Occupational Therapy)**

If covered, are there additional co-pays? YES NO

Is there a limit on modalities? YES NO

Do I have a deductible to meet? \_\_\_\_\_ Have I reached my deductible yet? YES NO

Do I have co-insurance? \_\_\_\_\_% \_\_\_\_\_%  
(insurance responsibility) (patient's responsibility)

Do I have an out-of-pocket maximum? YES NO

If yes, what is the maximum per person/per year? \_\_\_\_\_

Do I have a limit on the number of visits for office visits \_\_\_\_\_; manipulations \_\_\_\_\_; chiro. rehab. \_\_\_\_\_ **OR**  
are they all based on medical necessity? YES NO

If multiple procedures are performed at the same visit, how many visits will you count that as? \_\_\_\_\_

Do I have to go to a designated site to have X-rays covered by my insurance? YES NO

If no, then are X-RAYS covered when done at New Hanover Chiropractic Rehab Center? YES NO  
How are the x-rays paid? \_\_\_\_\_

Am I required to get a referral from my primary care physician? YES NO

Is pre-certification required? \_\_\_\_\_ Is there a pre-existing clause? \_\_\_\_\_

\*\*New Hanover Chiropractic Rehabilitation Center's fee schedule is based on usual and customary fees for the type of services provided. Your insurance policy is a contract between you, the patient and your insurance company. Therefore, it is to your advantage to know your benefits. Generally, your insurance policy will cover some portion of the services provided. **Please note: There is no guarantee of payment.** Should your insurance carrier deny payment, the total uncovered balance will be transferred to the patient and will be your responsibility. You are responsible for any deductibles, co-payments, co-insurance or ineligible charges. You are directly responsible for all supplies. Monthly statements will be sent to you advising you of your account balance. Payment must be made within the 30 day terms provided.

I attest that my insurance coverage and personal financial responsibilities regarding chiropractic treatment has been fully explained to me.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Patient Signature

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Office Personnel

In the event the patient chooses to not verify their benefits, please have them sign/date the following.

I, \_\_\_\_\_ have chosen not to verify benefits at this time. \_\_\_\_\_  
Patient signature date