

HOW DO I VERIFY MY INSURANCE BENEFITS?

Patient Name: _____

Insurance Company: _____

Insurance ID#: _____

Provider (circle):

Dr. Rebecca Asmar Dr. Caldwell

Dr. Asmar and Dr. Caldwell provide courtesy insurance billing. It is up to you, the patient/representative/guardian, to determine insurance coverage. In order to ensure you are aware of your benefits we request that you go through the following procedure before your visit. If you do not have insurance coverage, payment is due in full at time of service. It is the patient's responsibility to be aware of his/her coverage, as well as any deductible and maximums.

If insurance denies payment for any reason, the patient is responsible for the full balance within 30 days of receiving a bill.

Please follow the steps below to find out your benefits and eligibility.

First, Call the number on your insurance card listed for customer service, benefits and eligibility, or subscriber services and ask the representative the following questions:

1. Do I have naturopathic coverage? YES / NO
2. Beginning date of coverage _____. Ending date of coverage _____.
3. Do I need a *referral from my primary care physician* (PCP) for alternative services? YES / NO
4. Is the doctor I want to see (Dr. Rebecca Asmar / Dr. Deborah Caldwell) *In-Network* or a preferred provider for my insurance plan? YES / NO
5. For an In-Network doctor I have _____% coverage or \$_____ co-pay.
6. Is the doctor I want to see covered as an **Out-of-Network** Provider? YES / NO
7. For an Out-of-Network doctor I have _____% coverage or \$_____ co-pay

8. What are my benefits for the following services? ***Be sure to find out the benefits that apply to the doctor you are seeing; there will be different benefits depending upon whether the doctor is **IN or OUT of Network** with your insurance company and whether your plan includes Out-of-Network benefits.

Naturopathic: % Covered: _____ Co-Pay/Co-Insurance _____ Year Max _____

Acupuncture: % Covered: _____ Co-Pay/Co-Insurance _____ Year Max _____

Physical Therapy: % Covered: _____ Co-Pay/Co-Insurance _____ Year Max _____

Chiropractic: % Covered: _____ Co-Pay/Co-Insurance _____ Year Max _____

Massage: % Covered: _____ Co-Pay/Co-Insurance _____ Year Max _____

9. What is my deductible for the year, and have I met any part of that deductible?

Yearly deductible _____ Amount met _____ When does it re-set? _____

10. Are any of the specialties listed above subject to deductible? YES / NO

If so, which ones _____

Name of insurance representative I spoke with: _____

Date: _____

Please be aware that this is not a guarantee of payment. If an insurance company gives you inaccurate information, they may not honor the benefits that were quoted. I have verified my insurance benefits and listed them above. I understand that insurance billing is provided as a courtesy, and that I am responsible for all claims unpaid by my insurance company. I agree to be billed for any amount not paid by my insurance, and will submit payment to my physician within 30 days of receiving a bill. (Payment may be made by cash, check, or credit card.)

Name (Please print. Include parent / guardian name if patient is a minor)

Signature (Parent or guardian if patient is a minor)

_____/_____/_____

Date