Health Insurance Verification Questionnare

With Federal mandated patient privacy in the ever-changing healthcare industry, it is no longer convenient or permissible for our office to verify your insurance benefits. We appreciate your assistance with this very important matter.

Please reference your health insurance handbook, website or phone your health insurance directly in order to accurately verify the benefits below. A "**CoPay**" is the dollar amount or percentage amount paid by you the patient. If percentage amount is referenced in your handbook, it may also be referred to as a "**Co-Insurance**". **Annual Deductible** is the amount owed by you personally each year before insurance steps in to assist.

Do I have an HSA (Health Savings Account) plan? Y or N

Do I have an employer sponsored FSA (Flexible Spending Account)? Y or N

Do I have an employer sponsored HRA (Health Reimbursement Account)? Y or N

My Annual Deductible is $_____ and begins every (Jan / July / etc.) _____

Has my Annual Deductible been met? Y or N How much Deductible remaining? $_____

My co-pay amount for **"spinal adjustment or manipulations"** is ($ or %) _____
Are spinal adjustments or manipulations subject to the deductible? Y or N
Is there a yearly visit limit on spinal adjustment or manipulations? _____

My co-pay amount for **"extremity adjustments or manipulations"** is ($ or %) _____
Are extremity adjustments subject to the deductible? Y or N
Is there a yearly visit limit on extremity adjustments?_____

My co-pay amount for **"massage therapy"** is ($ or %) _____
Is massage therapy subject to deductible? Y or N
Is there a yearly visit limit on massage therapy?_____ If a Regence plan, my network massage therapy co-pay is ($ or %)_____VERSUS my out of network co-pay is ($ or)_____

My co-pay amount for **"office visit exams"** is ($ or %) _____ Are office visit exams subject to deductible? Y or N

My copay amount for modalities **(97530) Therapeutic Activities** is ($ or %) _____
My copay amount for modalities **(97012) Mechanical Traction** is ($ or %) _____

My co-pay amount for prescription orthotics usually referenced by **"durable medical device"** is ($ or %) _____ Are durable medical devices subject to the deductible? Y or N

Does my plan require pre-authorization for Chiropractic or Massage? Y or N

Print Name_____ Date_____

Signature_____ Staff Initials_____