GROUP POLICY#

SUBSCRIBER ID#

INSURANCE PHONE#

SECONDARY INSURANCE:

GROUP POLICY#

SUSCRIBER ID#

INSURANCE PHONE#

PRIMARY INSURANCE

-

BODY PART OR CONDITION TO BE TREATED:

[ ] FORMER PATIENT [ ] CLOSE TO WORK/HOME [ ] WEBSITE [ ] STREET SIGN [ ] SOCIAL MEDIA [ ] OTHER

REFFERED TO CLINIC BY [ ] PHYSICIAN [ ] INSURANCE PLAN [ ] FAMILY [ ] FRIEND

ALT PHONE ( ) -

PRIMARY PHONE ( ) -

ZIP

STATE

CITY

ADDRESS

DATE / /

INITIAL

LAST NAME

FIRST NAME

[ ] TRANSGENDERED [ ] NON-BINARY

[ ] MALE [ ] FEMALE FEFEMAFEMALEfEMAILFEhhhhfeggdfghdghdghfFEFEMAILfFfEFE((FfemFeFFeFEMALE fffFEMAFEMAILFemale

BIRTHDATE / /



EMERGENCY CONTACT

CONTACT

EMAIL

TYPE OF PLAN (*CIRCLE ONE*) **PPO** **EPO POS Medicare Other**:

**SELF-PAY**: **$190/EVALUATION AND $145/VISIT**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **In Network** | **Out of Network** |  |
| DOES THE PATIENT’S PLAN FALL UNDER THE COVERED CALIFORNIA PLANS? |  |  |  |
| WHAT IS THE PATIENTS RESPONSIBLILTY? |  |  |  |
| HOW MANY VISITS ALLOWED? |  |  |  |
| WHAT IS PATIENTS DEDUCTIBLE AMOUNT? **INDIVIDUAL?** |  |  |  |
| WHAT AMOUNT OF THE DEDUCTIBLE HAS BEEN MET FOR **INDIVIDUAL**? |  |  |  |
| WHAT IS THE PATIENT’S DEDUCTIBLE AMOUNT? **FAMILY?** |  |  |  |
| WHAT AMOUNT OF THE DEDUCTILE HAS BEEN MET FOR **FAMILY**? |  |  |  |
| WHAT IS THE PATIENT’S OUT OF POCKET AMOUNT? **INDIVIDUAL?** |  |  |  |
| WHAT AMOUNT OF THE OUT OF THE POCKET HAS BEEN MET FOR **INDIVIDUAL**? |  |  |  |
| WHAT IS THE PATIENT’S OUT OF POCKET AMOUNT? **FAMILY?** |  |  |  |
| WHAT AMOUNT OF THE OUT OF THE POCKET HAS BEEN MET FOR **FAMILY**? |  |  |  |

BASED ON THE FIGURE THAT WAS PROVIDED BY YOUR INSURANCE CARRIER (S), WE HAVE ESTIMATED THAT YOUR PATIENT RESPONSIBILITY WILL BE $\_\_\_\_\_\_\_NOT INCLUDING DEDUCTIBLE PORTION AND IS DUE AT THE TIME SERVICES ARE RENDERED. YOU MAY HAVE A CO-PAY THAT IS MORE THAT WHAT IS CHARGED FOR THE DATE OF SERVICE, IN WHICH CASE YOU MAY BE BILLED FOR THE DIFFERENCE. SHOULD YOUR CO-PAY AMOUNT BE LESS THAN WHAT WAS CHARGED FOR THE DATE OF SERVICE, YOU WILL BE REFUNDED THE DIFFERENCE. **PLEASE BE ADVISED THAT YOUR INSURANCE COMPANY MAY DIRECTLY MAIL YOU A CHECK(S) FOR THE SERVICED RENDERED FROM OUR OFFICE. CHECK(S) NEED TO BE ENDORSED OVER TO OUR OFFICE ALONG WITH THE EOB’S (EXPLANATION OF INSURANCE BENEFITS) FOR APPROPRIATE PROCESSING TO YOUR ACCOUNT.**

WE HAVE VERIFIED YOUR BENEFITS WITH YOUR INSURANCE AND WE ARE INFORMING YOU OF THESE BENEFITS. WE ARE NOT RESPONSIBLE FOR YOUR BENEFITS AND DO NOT GUARENTEE THAT YOUR BENEFITS WILL BE PAID BY YOUR INSURANCE. IT IS YOUR RESPONSIBILITY TO PAY ANY DEDUCTIBLE AMOUNT, CO-INSURANCE, OR AN “NON-COVERED” ITEMS (S\_)