Insurance Information

Please call your insurance company for any information that you do not know!

Patient's Name___________________________________

Relationship to insured: Self Child Spouse
Insured's Name if not Patient____
Insured's Social Security #________________ Insured's DOB___________________

Insured's address, if different from patient: _____________________________________

City________________ St_____ Zip__________ Phone #________________________

Insurance Co. Name____
Policy #_________________________ Group #_____________________________

Chiropractic Coverage? Y N If yes, is there a deductible: $__________________

Has it been met for this year? Y N When does plan year start?____________________

Do you have Non-PPO coverage? Y N (Dr Kris & Dr Kenzie are PPO's for BCBS, ODS, Premera & Lifewise **only**!)

Is this per family member? Y N Is this total for the whole family? Y N

Is there limits on care? Y N If yes, maximum payment amount per year $_________

Max # visits per year_________ Is there a co-pay? Y N Co-pay amount $__________

Is this an **80/20%, 70/30%, 60/40%, 50/50%**, plan? Y N Or other___________%

Does insurance pay for diagnosis other than musculoskeletal? Y N

Does your policy cover diagnostic testing ordered by a chiropractor? Y N
X-ray Diagnostic Ultrasound MRI/CT EKG QEEG Blood work
Neurofeedback/Biofeedback 90901 or 95812 for what diagnosis do they pay?_________

I authorize Peterson Clinic to receive payments directly from my insurer.
I acknowledge that I will remain on a cash basis until this form is completed in full.
A receipt will be provided for my convenience to send to my insurance until such time that this information is provided in full to Peterson Clinic.

Signed:____________________________________ Date______________________