Private Patient Health Insurance Verification Questionnaire

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 "**co-pay**" is the dollar amount or percentage amount paid by you the patient. If a percentage amount is referenced in your handbook, it may also be referred to as a "**co-insurance**". *Annual Deductible is the amount paid by you personally each plan year before insurance steps in to assist.*

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

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

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

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

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

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

7. 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? _____

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

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

10. My co-pay for x-rays is ($ or %) _____ Are x-rays subject to deductible? Y or N

11. 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

12. Does my plan require pre-authorization for Chiropractic and/or Massage? Y or N
Thru which company? _____

Name _____ Signature _____Date_____
Staff Initials