Clayton Wellness Center

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PATIENT INSURANCE INFORMATION

Please be aware that we do not accept any insurance plans, but we will provide you with an insurance receipt for you to submit to your insurance company for reimbursement if you are eligible. ***If you are a Medicare patient, we will submit office visit claims to Medicare on your behalf, with your consent.***

Please complete this form and provide us with your insurance card so that we may contact your insurance company to determine what coverage, if any, you have for out-of-network chiropractic care.

Patient's Full Name: _____ SSN: _____
Name of Insurance Holder, Parent or Guardian (if different from patient):
_____
Insurance Holder's Relationship to Patient: _____
Insurance Holder's Mailing Address: _____
City: _____ State: _____ Zip: _____
Patient's Date of Birth: _____ / _____ / _____
Is the patient's primary condition related to work or an accident while at work? YES / NO
If yes, please explain: _____
_____
Is the patient's primary condition related to an automobile accident? YES / NO
If yes, please explain: _____
_____
Are you covered by Medicare? YES / NO
If you answered YES, please provide us with your Medicare card and information below.

Insurance Company: _____
Policy Number or Member ID: _____
Insurance Company Phone Number (for Providers): _____

Secondary Insurance Company (if any): _____
Policy Number or Member ID: _____
Insurance Company Phone Number (for Providers): _____

I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS AN INSURANCE CLAIM. I UNDERSTAND THAT CLAYTON WELLNESS CENTER DOES NOT ACCEPT INSURANCE PAYMENTS AND THAT I AM RESPONSIBLE FOR HANDLING THE ENTIRE CLAIM PROCESS.

Signature: _____ Date: _____

FOR OFFICE USE ONLY:

OUT-OF-NETWORK CHIRO COVERAGE? YES/NO MAX NUMBER OF VISITS PER YEAR: _____
EFFECTIVE DATE OF COVERAGE: ___ /___ /____ MAX OUT-OF-POCKET PER YEAR: $_____
DEDUCTIBLE: $_____
CO-INSURANCE: _____% or $_____ co-pay DEDUCTIBLE MET: $_____ O-O-P MET: $_____
NOTES: _____

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