

Your Information

Name: _____

Address: _____

Phone: _____

Date of Birth: _____

Insurance Company: _____

Phone: _____

Policy Number: _____

Questions to ask your insurance company

| | | | |
|---|-----|----|-------------------------------|
| Do I have Chiropractic benefits? | Yes | No | |
| Physical Therapy benefits? | Yes | No | |
| Massage Therapy benefits? | Yes | No | |
| Are X-rays covered? | Yes | No | |
| Do I have a deductible? | Yes | No | Annual amount \$ _____ |
| Have I met it yet? | Yes | No | Balance remaining \$ _____ |
| Is it per calendar year (i.e.: January-December)? | Yes | No | Other _____ |
| Is there a limit to the number of visits I can receive? | Yes | No | Number of visits _____ |
| Is there a maximum dollar amount per year that my plan will pay towards this treatment? | Yes | No | \$ _____ |
| What percentage does my insurance cover? | Yes | No | _____ % |
| Do I have a co-pay for each visit? | Yes | No | \$ _____ |
| Is a referral required? | Yes | No | |
| Do I have out-of-network benefits? | Yes | No | |