

**INSURANCE VERIFICATION**

**PATIENT NAME:**

**INSURANCE COMPANY NAME:**

Insured’s Name: Relationship to Patient:

Policy I.D. Number Group Number:

Insured’s Date of Birth:

Effective Date of Policy: Is there a deductible: € Y € N

Co-Payment or Co-Ins. € Y € N If yes, how much?

Is the practitioner in network? € Y € N

**Secondary Insurance:**

Insured’s Name: Relationship to the Patient:

Group Number: Policy I.D. Number

Insured’s Date of Birth: Insurance Company Phone:

**Our Financial Policy And How It Works For You**

Whether you are paying cash or using insurance, you are always ultimately responsible for your bill. Co-pays are due at the time of service.

**Your Responsibilities**

* Please know and understand your insurance benefits.
* Please pay your co-pay at the time of your treatment.
* Please read and keep your Explanation of Benefits statements from your insurance.
* Please follow up promptly with claims not paid by your insurance company, or you will be billed directly for them.
* **Please make any cancellations with at least 12 hours’ notice or you may be billed.**

Patient’s signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_