

INSURANCE VERIFICATION FORM

Office Name: Dr. Jeff Snyder, LLC d/b/a Snyder Family Chiropractic

TAXID#: 20-3865529 NPI Group#: 1003000670

Should you have insurance and want to use it for your symptomatic care at our office, we will need for you to contact your insurance company and complete the information below. **Until this information is complete, we will provide you care, however, you will need to pay for service at the time service is rendered. We will be happy to file your claims for you upon receipt of this completed form.**

Verified By: _____ Date: _____

Speaking With: _____ Operator ID# or Extension: _____

Patients Name: _____ DOB: _____

Insurance Company: _____ Telephone: _____

ID# _____ Group # _____

Effective Date: _____ Is the *policy holder* the patient? YES NO

Policy Holder _____ Chiropractic Benefits: YES NO

IN Network Benefits: YES NO Ded \$ _____ Met? YES NO Copay \$ _____

OUT of Network Benefits: YES NO Ded \$ _____ Met? YES NO Copay \$ _____

Pre-certification Required? YES NO Percent Covered: _____

Any Limitations? _____

Referral Required? YES NO X-Ray Referral Required? YES NO

Covered Benefits: X-Rays: YES NO if yes, _____ % MRI Require Pre-Cert? YES NO

Therapies a Covered Benefit? YES NO Therapies CAPITATED? YES NO Where: _____

Adjustments of Spine	YES NO Code 98941	Adjustments of Extremities	YES NO Code 98943
Massage Therapy:	YES NO Code 97124	Activities of Daily Living	YES NO Code 97535
Therapeutic Exercises:	YES NO Code 97110	Therapeutic Activities	YES NO Code 97530
Mechanical Traction:	YES NO Code 97012	Neuromuscular Reeducation	YES NO Code 97112
Manual Therapy	YES NO Code 97140		

DME Products: Is a Referral from *Primary* Required? YES NO *PRECERT Required*? YES NO

Orthotics: YES NO Code L 3020 Cervical Pillow: YES NO Code L 0510

Tens Unit *Purchase*: YES NO Code E 0730 Tens Unit *Rental*: YES NO Code E 0730RR

Claims Accepted Electronically: YES NO

Billing Address: _____

Insurance Authorizations and Releases

NAME _____

CASE# _____

Consent for Treatment

I, hereby understand hereby authorize the doctor and whomever he/she may designate as his/her Assistant(s) to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as is necessary. I recognize not all services performed will be covered by my insurance carrier; therefore I may need to sign a **Service Waiver** to allow for those services to be performed. I also, certify that no guarantee or assurance has been made to the results that may be obtained. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that my amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account **HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.**

Authorization to Release Medical Information

I authorize the doctor to release any medical information pertinent to my treatment plan to, _____ representative for review. This authorization for release of information shall remain valid for the term of my coverage under my current policy. I certify that all insurance information given to this clinic is correct and complete.

Request For Payment of Benefits To Provider of Care

I hereby authorize _____ Insurance Company/Insurance Administrator to pay by check, and for it to be mailed directly to: **Dr. Jeff Snyder, LLC; PO Box 761; OAKS, PA 19456.** The expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said applicable charges. I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill. I understand that if any "Explanation of Benefits" which includes a check is mailed to my home by my insurance provider I will sign the check and turn it over to the correct provider with all the attached paper work. If I receive a check then cash it, it will be my responsibility to pay the provider the proper amount to cover all my services. If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct above noted insurance company to mail the check to the address noted in this section. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above mentioned assignee, and I agree to pay in a current manner and balance of said professional service charges over and above this insurance payment.

X-Ray / Medical Records Release

I hereby request and authorize you, your employees and agents to furnish to the person(s) listed below or anyone designated in writing by them. all copies of records and reports, including copies of x-rays and photo-static copies, abstracts or excerpts of all records and any other information they may request relating to any examination, treatment or opinion concerning any condition that I may have had in the past, now have, or may have in the future.

(where applicable) Attorney Representation and Protection of Balance

I, the undersigned patient am directing my attorney, _____, to pay any outstanding bills out of my Settlement and in effect, protecting any such balance. I hereby make and declare the instructions herein contained to be irrevocable. I fully understand that I am directly responsible for all medical bills and thus agreement made solely for the doctor's additional protection and consideration of his awaiting payment I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but will require me to make payment on a current status.

(where applicable) Consent For Treatment of Minor

I hereby authorize the doctor and whomever he/she may designate as his/her assistants, to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as he/she deems necessary to my (indicate relationship of child) _____ (child's name) _____ and grant permission for my child to receive chiropractic care.

A photocopy or fax of this Assignment shall be considered as effective and valid as the original.

Please forward this to: (Name) _____

Address) _____

Guardian / Patient Signature _____

Date ____ / ____ / ____ Witness _____

(on behalf of _____, a minor