Patient Insurance Benefits

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Use this form when contacting your insurance company to confirm your natural medicine health insurance benefits. It is patient responsibility to know your insurance benefits when receiving treatment in our office.

Effective date: ____/____/____ Yearly deductible $_____

Naturopathic		Acupuncture	
_____ % coverage	$_____ Copay amount	_____ % coverage	$_____ Copay amount
_____ Number of visits	☐ Yes* ☐ No Referral required?	_____ Number of visits	☐ Yes* ☐ No Referral required?

**If your insurance requires you to obtain a referral or prior authorization, please obtain this before your appointment. You will be responsible for the cost of the visit and lab work if prescribed otherwise.*

Is an Annual Physical a covered benefit? ☐ Yes ☐ No

Does your insurance require you to choose a primary care provider? ☐ Yes ☐ No

If yes, who is your primary care provider? _____

It is patient responsibility to record the number of benefits used throughout your treatment. Should this form not be completed before your visit, you the patient assume all responsibility for the charges and knowledge of benefits in all forthcoming visits.

_____ Patient Signature

_____ Patient's Guardian Signature (IF MINOR)

_____ Date