INSURANCE COVERAGE INFORMATION

Complete below, sign where indicated, then provide your insurance card(s) to reception. Digital cards, front and back, should be emailed to thebackalleychiro@yahoo.com. Please complete the following as listed on your insurance card:

First Name _____ **Middle** Initial _____ **Last** Name _____ Date of Birth ____/____/____

Primary Insurance_____ ID # _____ Insured: ☐Self ☐Spouse ☐Parent ☐Other

Insured, if not self: Full Name _____ Phone # _____ Date of Birth ____/____/____

Social Security Number _____ - _____ - _____ Employer _____

Secondary Insurance_____ ID # _____ Insured: ☐Self ☐Spouse ☐Parent ☐Other

Insured, if not self: Full Name _____ Phone # _____ Date of Birth ____/____/____

Social Security Number _____ - _____ - _____ Employer _____

Tertiary Insurance_____ ID # _____ Insured: ☐Self ☐Spouse ☐Parent ☐Other

Insured, if not self: Full Name _____ Phone # _____ Date of Birth ____/____/____

Social Security Number _____ - _____ - _____ Employer _____

INSURANCE POLICY & PROCEDURES

All policies and procedures are available on our website for reference at any time. Office policies and procedures are updated regularly. Your signature below indicates you have read, understand, and agree to the above policy and procedures regarding insurance coverage billing practices.

The Back Alley Chiropractic fully complies with all our insurance contracts. It is not our custom to balance bill amounts not allowed by your insurance policy. It is your responsibility to update us with your current insurance information. **If you fail to notify us of a change in carrier, termination of coverage, and/or exceeded benefits, you will be 100% responsible for payment per your insurance policy's allowable amount.** Any insurance you may have is an agreement between you and your insurance carrier and you are financially responsible for the payment of any services rendered.

The Back Alley Chiropractic strives to contract with all local insurance plans. In special cases this may not be possible. Out-of-network coverage often requires a referral or pre-authorization by a Primary Care Physician (PCP). **It is your responsibility to know if a referral or pre-authorization is required to see specialists.** If a referral is required, it is up to you to arrange the submission per your insurance carrier by your PCP. If a referral is not received, you will be 100% responsible for payment.

The Back Alley Chiropractic does its best to verify and interpret your benefits and eligibility with regard to chiropractic and therapeutic procedures. Occasionally we are given incorrect information and can make mistakes. You are responsible for balances owed if your Explanation of Benefits (EOB) shows a different amount owed from your verification. **Any questions about balances owed should be directed to your insurance carrier's member services.**

According to your insurance carrier, you are responsible for co-pays, deductibles and/or co-insurances. **Co-pays, deductibles and/or co-insurances are fees that cannot be waived or discounted.** You will be responsible for your portion of the bill, which is due at the time of service, unless other arrangements have been requested in advance.

If your insurance carrier is to be billed prior to payment collection, once we receive an EOB from your insurance carrier an itemized bill will be sent to you with any balance owed per your insurance plan.

According to your insurance carrier, verification of your benefits is not a guarantee of payment and final determination will be made for payment of services ***after*** a claim is received. The Back Alley Chiropractic is committed to providing the best treatment for our patients. Our professional fees are usual and customary per local state and federal rate tables.

I authorize the release of any medical or other information necessary to process my claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. I authorize payment of medical benefits to The Back Alley Chiropractic and its physicians or supplier for services received. To the best of my ability, the information I have supplied is complete and truthful.

Patient or Parent/Guardian Signature _____ Date _____

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