HUMMINGBIRD HEALING ARTS

HONORING YOUR HEALING PATH

INSURANCE VERIFICATION FORM

Dr. Allison Scholes
NPI: 1235421124

Date_____

Patient'sName:_____

Date of Birth:_____

Please have the following information when calling your insurance company:

- ☐ Insurance company's phone number (on the back of your card):_____
- ☐ Policy holders name and DOB (if different from patient):_____
- ☐ Insurance ID number and Group Number

Please obtain and verify the following information. Your claim cannot be processed without this information. Thank you.

- ☐ 1. Ask for the name of the person giving you this information:_____
- ☐ 2. Ask if your insurance company is "in network" with
  Allison Scholes, DC NPI: 1235421124
- ☐ 3. Ask if you have chiropractic coverage for "in network" providers. If yes, please continue to verify type and amount of coverage.
- ☐ A. What is the yearly deductible: Per Person: _____ Per Family: _____
- ☐ B. Does the deductible apply to chiropractic (exam, x-rays, adjustments): YES NO
- ☐ C. How much of the deductible has been met this year: _____

Allison Scholes, DC
206.856.3232
alliehumm@sacred-aha.com
www.sacred-aha.com

☐ D. What is the co-pay or co-insurance for the exam : _____

☐ E. What is the co-pay or co-insurance for the x-rays : _____

☐ F. What is the co-pay or co-insurance for the adjustments : _____

☐ G. Is there a limit to the number of visits or $ amount? YES NO

☐ If yes, how many visits are allowed and/or what is the $ limit? _____

☐ H. Are services limited by “Medical Necessity”? YES NO

☐ I. Do they cover Wellness or Maintenance Care? YES NO

☐ J. What is the effective date of the policy: _____

☐ L. Name and address of the insurance office where the claims are sent:

_____

_____

Thank you for obtaining and verifying this information with your insurance company. We expect they will reimburse you or your account as noted above.

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HUMMINGBIRD HEALING ARTS INSURANCE INFORMATION

Insurance is a contract between the insured (patient) and the insurance company. The following information will help you to understand how insurance can be utilized in our office and the details regarding your participation in the process.

PLEASE READ ALL THE FOLLOWING INFORMATION TO CLARIFY INSURANCE PROCEDURES.
Insurance companies, such as HMOs, PPOs and others, create their own guidelines and are not required to cover chiropractic services. If chiropractic services are covered, the amount and type of reimbursement varies according to the policy that has been purchased by you or your employer. (See reverse for details)
If you have determined that your insurance will cover your care in our office, they will require direct billing from us. They are responsible to you, as the subscriber, not to us, the provider. You can utilize the above "Insurance Verification Form" when you inquire about your coverage.
We will supply them with the necessary information for the insurance to remit payment to our office on your behalf. Please understand that you are responsible to pay for all services not covered by your insurance company including deductibles, co-payments and any other balances not reimbursed by the insurer.
Verification of benefits does not guarantee that the insurance company will cover the services provided.
Additionally, insurance is designed to be used for acute/sub-acute conditions only. In order to justify coverage, medical necessity is often needed to be demonstrated through thorough and periodic examinations. Insurance companies do not cover holistic/wellness/preventative chiropractic care unless the plan specifies otherwise.

Hummingbird Healing Arts' insurance policy is that we do not bill insurance for more that 12-14 visits per episode over a 3 month period unless we can provide strong evidence of medical necessity; as doing so is a breach in the contract with the insurance network. All visits outside of an acute/subacute treatment plan are considered corrective or wellness care and will be billed to the patient at our wellness care self-pay rate. Your plan may offer more than 10-12 visits, but these are only for acute care. We must be able to show both evidence that you are experiencing an acute episode/injury, and we must be able to show that the care provided is improving your acute condition.

I HAVE READ, UNDERSTAND AND AGREE TO COMPLETE ALL FORMS NECESSARY TO ALLOW HUMMINGBIRD HEALING ARTS TO ASSIST ME WITH INSURANCE REIMBURSEMENT. I UNDERSTAND THAT I AM ENCOURAGED TO ASK QUESTIONS FOR FURTHER UNDERSTANDING AND THAT I AM PERSONALLY RESPONSIBLE FOR ALL SERVICES RECEIVED SHOULD MY INSURANCE DENY COVERAGE FOR SERVICES PROVIDED.

Patient Name Printed: _____

Patient Signature: _____ Date: _____

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