Purity Integrative Health & Wellness Center, PLLC

INSURANCE INFORMATION

_____I DO NOT have insurance and I am paying for each visit at time of service at the time-of-service discount. I understand that if I do not pay the day of my visit, I will not receive the time-of-service discount.

_____I have insurance, but I am aware that my insurance will not cover Naturopathic services and I am paying for each visit at time of service at the time of service discount. I understand that if I do not pay the day of my visit, I will not receive the time-of-service discount.

_____I have personally verified that my insurance will cover today's service. Please bill my insurance and I will pay my copay TODAY and my deductible or coinsurance or any remaining balance.

My copay is: $________

My insurance will cover ______% of Naturopathic Services and I am responsible for the remaining.

Insurance Information

This plan is: ____ Through a group/employer plan _____ A private/individual plan ____ A state funded plan

Insurance Carrier: ____

Patient Name: ____ DOB: _______

Patient's Address: ________________________________ City: ________________ State: ____ Zip: _______

Patient's Phone #: __________________________________ Cell Phone: ____________________________

Patient's Employer: ____

Subscriber ID:____________________________________ Group #: _______________________________

Subscriber: __________________________________ Subscriber SS#: __________________ DOB: _______

Subscriber's Employer: ____

Relationship to Patient: ____

Insurance Billing Address (see back of your card): ____

Insurance Phone #: ____

I, ____________________________, certify that the above information is correct to the best of my knowledge.

Signature: ____ Date: _________________

Revised 10/10/23

INSURANCE VERIFICATION

Providing correct insurance information is the responsibility of the patient. All patients must complete the insurance verification form before seeing the doctor. Naturopathic Medicine is not always covered the same as conventional medicine. COMPLETEING THIS FORM REQUIRES A PHONE CALL TO YOUR INSURANCE AND SHOULD BE DONE A MINIMUM OF 72 HOURS PRIOR TO YOUR SCHEDULED APPOINTMENT.

It is vital that this form is filled out in its entirety in order for the billing process to proceed smoothly. If your insurance changes, please present your insurance card at the next visit AND fill out this form again.

It is the patient's responsibility to be aware of her/his coverage and co-pay, as well as any deductible and maximum. It is important that all questions on this form be answered, even if you do not plan on seeking that benefit.

Name: ____ DOB: __________________________________
Insurance Company: _________________________________ Phone Number: _________________________
ID Number: ____ Group Number___________________________
Subscriber: ____
Representative I Spoke with: ___________________________ Confirmation Number: ____________________
Date: ________________________ Time: _____________
Do I have a Calendar year or Plan year? ______________________

QUESTIONS TO ASK: (FOR INDIVIDUAL / FAMILY AMOUNTS)

	Yes / No	Individual Amount?	Amount Remaining?	Family Amount?	Amount Remaining?
Do I have a Deductible?					
Do I have an Out of pocket Deductible?					

Notes or Questions:

DO I HAVE BENEFITS FOR:

	Copay Or Co-insurance	Amount?	Does it apply to my deductible?	Visit Limit?	Amount Remaining?	Pre-Authorizations / Referrals?
Naturopathic Medicine						
Laboratory Services (Is there a preferred lab: LabCorp or Quest?)						

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DISCLAIMER:

ASSIGNMENT OF INSURANCE BENEFITS & VERIFICATION ACKNOWLEDGEMENT

I acknowledge that the above-listed coverage information is valid and correct. I understand that benefit verification is not a guarantee of coverage by my insurance company, and that I am financially responsible for all services rendered to me by Purity Integrative Health & Wellness Center, PLLC dba Purity Health. I also understand that all secondary insurance billing services provided by Purity Health on my behalf are performed on a courtesy basis and benefits for my secondary must also be verified. Secondary insurance not provided at time of service will not be billed. I authorize release of information in my medical history to my insurance company and assign all benefits for unpaid services to Purity Health. A photocopy of this authorization shall be considered as effective as the original. Assignment will remain in effect until revoked by me in writing.

PRINTED NAME: ____

SIGNATURE: ____

…….

IF YOU DO NOT MAKE THIS PHONE CALL, PLEASE SIGN BELOW:

***At this time, I do not wish to verify my insurance benefits and realize that I will be responsible for any services that we discover are not covered under my plan; as well as any copays, coinsurances, deductibles, or services we learn later that needed a pre-authorization.

PRINTED NAME: ____

SIGNATURE: ____