INSURANCE BENEFITS VERIFICATION
(Please allow 1 hour for this form)

In order for our office to bill your insurance, this form must be completed before your appointment. Otherwise payment is due at time of service.

Everyday Wellness is committed to providing the best care for our patients. As a service we bill most primary insurance carriers directly. However, patients are responsible for all charges resulting from treatment provided by their physician. **We bill primary, but we do not bill secondary insurance.** We provide all the necessary paperwork for the patient to submit to their insurance. **If after 90 days Everyday Wellness Clinic has not received payment from the insurance company, the patient is responsible for the account balance.**

Providing correct insurance information is the responsibility of the patient. All patients must complete the insurance verification form before seeing the doctor. 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.
It is the patient's responsibility to be aware of her/his coverage and co-pay, as well as any deductible and maximum.

Please complete the following 2 pages in their entirety and attach a front & back copy of your insurance card.

I. This is a: ☐ New Insurance Application ☐ Change of Insurance Application

A. Patient Name

Address

City State Zip

Phone: Work Cell Home

Social Security # DOB:

B. Insured's Name (if different)

Insured's Date of Birth / / Relationship to Patient

Address

City State Zip

Phone: Work Cell Home

C. Name of Insurance Company

Claims Address

City State Zip

Phone Group or Policy #

Insurance ID #

II. **Follow steps 1-9 when calling to verify out benefits and eligibility.**
To start, call the number on your insurance card listed for customer service, benefits and eligibility, or subscriber services. Ask the representative the following questions.

1. **With whom am I speaking?** (This is important if there are any problems with coverage.)
Name of the representative Date

2. **When did my coverage begin and when did it end?**
Beginning Date of Coverage Ending Date of Coverage

3. **Is the doctor in my plan (Laura Torgerson, ND)?**
If they say no, ask, **Is Everyday Wellness Clinic** in my plan? ☐ **Yes** ☐ **No**

4. **Is the doctor "in network" ☐ or "out of network?" ☐**
If the doctor and the clinic are "out of network," ask **Can I see a naturopathic doctor/physician and/or acupuncturist "out of network?" ☐ Yes ☐ No**

5. **Are my alternative claims billed to American Specialty Health**, and **Do I have ND coverage**?
☐ **Yes** (If yes, **What is my co-pay?** $ ☐ **No**

6. **Is a naturopathic doctor considered a primary care provider (PCP) on my plan?** (This is important. NDs are licensed primary care providers (PCPs) in the state of Oregon, however insurance companies may not cover them as primary care providers.)
☐ **Yes** ☐ **No**

7. **Do I need a *referral* from a medical doctor, primary care provider (PCP), for alternative services?**
☐ **Yes** ☐ **No**

8. **Can my naturopathic doctor perform my annual physical or gynecological exams?**
☐ **Yes** ☐ **No**

9. **Does my insurance cover an annual wellness exam? ☐ Yes ☐ No** With labs? ☐ **Yes** ☐ **No**

10. If you are female ask: **Does my insurance cover gynecological care by a naturopathic doctor?**
☐ **Yes** ☐ **No**

11. Ask about your deductible. **What is the amount and has any or all of it been met?**
Deductible $ Amount of Deductible met so far $ Date

What year is my deductible based on? Calendar year ☐ Fiscal year ☐

12. **What are the preferred laboratories?** LabCorp, Providence, Quest, Legacy, other:

13. What are your benefits? This is very important. **Do have a co-pay or do I owe a percentage? Do I have a maximum amount that can be spent?** Be sure to find out which benefits apply to the doctor you are seeing. There will be different benefits depending on whether the doctor is In-Network or Out-of-Network, and whether your plan includes Out-of-Network benefits.

Naturopathic:

Office Visit	_____	% Covered or	$	_____	Co-pay	Year Max	_____
Lab Work	_____	% Covered or	$	_____	Co-pay	Year Max	_____
Physical Medicine/Chiropractic	_____	% Covered or	$	_____	Co-pay	Year Max	_____
Supplements	_____	% Covered or	$	_____	Co-pay	Year Max	_____
Acupuncture	_____	% Covered or	$	_____	Co-pay	Year Max	_____
Massage	_____	% Covered or	$	_____	Co-pay	Year Max	_____

ASSIGNMENT OF INSURANCE BENEFITS & VERIFICATION ACKNOWLEDGMENT

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 Everyday Wellness Clinic (EWC). I also understand that all out-of-network (non-contracted) insurance billing services provided by EWC on my behalf are performed on a courtesy basis and can be discontinued by either myself or EWC, with written notice, at any time. I authorize release of information in my medical history to my insurance company and assign all benefits for unpaid services to EWC. A photocopy of this authorization shall be considered as effective as the original. Assignment will remain in effect until revoked by me in writing.

Signature Date

Must be signed or verification is void.