Carlson Wellness Clinic

PLEASE UPDATE US IF ANY CONTACT INFORMATION HAS CHANGED

Name_____

◯ No Change ◯ New Address _____

◯ No Change ◯ Phone Number_____

◯ No Change ◯ Email_____

INSURANCE COVERAGE

◯ No change in benefits/coverage for the new year

New insurance company (mark new company, present card to front desk)

Reset Insurance Choice

◯ BCBS ◯ CIGNA ◯ PREFFERED ONE

◯ MEDICA ◯ MEDICARE ◯ UNITED HEALTHCARE

◯ HEALTHPARTNERS ◯ AETNA ◯ UCARE

OTHER: _____

Primary policy holder: _____ Date of birth: _____

INSURANCE/OUT OF POCKET EXPENSES

**We ask all copays, supplement costs, durable medical supplies, and any other out of pocket expenses are paid at the time of service**

Each insurance company is different; we cannot guarantee the amount you will owe. Some insurance companies do not cover certain services. Exams, Re-Exams, Electrical Stim Therapy, Intersegmental Traction, Manual Therapy/Muscle work, Acupuncture, Smart Tool Treatment, and Chiropractic Treatment for an Extremity are services **not covered by Medicare** insurance policies. Any therapy that is an uncovered service by your insurance company will be your responsibility as laid out in the Financial Disclosure Form. If you have any specific insurance coverage questions or concerns first contact your HR department or the number on the back of your insurance card.

Patient is responsible for all uncovered services. Maintenance/supportive care is not a covered service by any health care plan. Uncovered services are not submitted to any insurance company

I understand that this is not a guarantee of payment and that I am responsible for verifying and tracking my policy coverage and limitations. If for any reason my insurance company denies payment, I understand that I am responsible for all uncovered charges.

NOTICE OF PRIVACY PRACTICES

Carlson Wellness Clinic is required, by law, to maintain the privacy and confidentiality of your protected information and to provide our patients with notice of our legal duties and privacy practices with respect to your health information. Copies of the complete Privacy Notice are available on request.

HIPPAA Compliance

By way of my signature, I provide Carlson Wellness Clinic with my authorization and consent to use and disclose my protected health care information for the purpose of treatment, payment, and health care operations as described in the Privacy Notice.

Signature_____ Date_____