



Northern Hills Chiropractic & Wellness Centre

36 Panatella Blvd NW Calgary, AB T3K 6K7 ph: 403-567-0400 info@northernhillschiro.ca

CHIROPRACTIC & WELLNESS HEALTH INSURANCE INFORMATION

Our office is NOT set up to direct bill insurance companies - except as stated in this form. It is important that you understand that health and accident insurance policies are an arrangement between you and your insurance company. Our office will help you complete any of the necessary forms to ensure prompt reimbursement from your insurance company. However you are personally responsible for all cost incurred in our office.

Insurance Company: _____

Patient's First Name: _____ Patient's Last Name: _____

Date of Birth: _____ Gender: M / F

Primary Coverage Information

First Name: _____ Last Name: _____

Relationship: _____ DOB: _____

GROUP NUMBER: _____ ID#: _____

Secondary Coverage Available?: No Yes (please fill in required Information)

Relationship: _____ First Name: _____ Last Name: _____

DOB: _____ Insurance Company: _____

GROUP NUMBER: _____ ID#: _____

I _____ authorize payment be made directly to Northern Hills Chiropractic & Wellness Centre. I acknowledge any denied or outstanding claim will be my responsibility to claim.

☒ _____ Date: _____

DIRECT BILLING INSURANCE & PAYMENT ARRANGEMENTS

The Canadian Personal Privacy Act prohibits us from accessing any information from your insurance carrier. It is the responsibility of the insurer to know the details involved in your plan (annual maximums, frequencies, other limitations.) We extend the courtesy to bill your insurance directly, however, to avoid any discrepancies please be fully aware of the particulars of your plan so you can use your benefits to the maximum.

We will direct bill your insurance carrier. **You will be required to leave a credit card number on file** & any outstanding amount will applied to that credit card once your insurance carrier has paid us its portion. A receipt for payment will be mailed/emailed/given to you. If we receive an explanation of benefits from your insurance carrier after your visit you will be required to pay the outstanding balance before you leave.

I have read and understood the above policies.

Patient/ or Guardian Signature

Date