Dr. Maria Maricich The Wellness Doctor (208) 726-6010

This is the information we need in order to determine your financial obligation:

Be sure to bring your card with you if you would like us to submit claims on your behalf.

Date:_____ Your Insurance Company:_____

Patient Name:_____ Patient Birthdate:_____

Insured Name:_____ Insured Birthdate:_____

Insured Address (if different than patient**):_____ Sex: M___F___**

Relationship of Patient to Insured: Self:___ Spouse:___ Child:___ Other:___

Illness/Injury/Accident Date:_____ Time:_____ AM/PM_____

Social Security #_____-_____-_____

Questions to ask your insurance company:

Be sure to say your chiropractor is out of Network!!

Is there Out of Network coverage for Chiropractic care?_____

Are my benefits based on a calendar year? (i.e. Jan-Dec) Or is it some other?_____

Is there a deductible?_____ How much?_____ How much has been met so far?_____

Is there a co-pay?_____ How much?_____ Is there an out of pocket max, how much?_____

Do I pay a percent each visit?_____ How much is covered per visit?_____

Is there a family deductible? How much?_____ How much has been met so far?_____

Is there a yearly benefit max for chiropractic? (This will be a $$ amt. or # of visits)_____

Are the benefit max (# of visits or $ amount) being counted while meeting the deductible?_____

Is the coverage for chiropractic shared with other therapies like acupuncture or massage?_____

If insurance verification is not completed, there will be a $25 service fee for the office to verify.

Until verified, patient agrees to pay in full at the time of service.