Patient Name: ___________________________________

EXTENDED HEALTH CARE COVERAGE FORM

Insurance Company Name	Plan/Policy #	Group/ID #	What is the Benefit Year?
Telephone #		Fax #	
Policy Holder Name		Policy Holder Date of Birth (YYYY/MM/DD)	

CHIROPRACTIC
Maximum ($) coverage per benefit year? ______________
% of coverage per visit? ______________
Reasonable and necessary per visit? ______________
Medical doctors referral needed? ☐Yes ☐No
Additional Notes:

PHYSIOTHERAPY
Maximum ($) coverage per benefit year? ______________
% of coverage per visit? ______________
Reasonable and necessary per visit? ______________
Medical doctors referral needed? ☐Yes ☐No
Additional Notes:

MASSAGE THERAPY
Maximum ($) coverage per benefit year? ______________
% of coverage per visit? ______________
Reasonable and necessary per visit? ______________
Medical doctors referral needed? ☐Yes ☐No
Additional Notes:

ACUPUNCTURE
Maximum ($) coverage per benefit year? ______________
% of coverage per visit? ______________
Reasonable and necessary per visit? ______________
Medical doctors referral needed? ☐Yes ☐No
Covered if TCM completes? ☐Yes ☐No
Additional Notes:

NATUROPATH
Maximum ($) coverage per benefit year? ______________
% of coverage per visit? ______________
Reasonable and necessary per visit? ______________
Medical doctors referral needed? ☐Yes ☐No
Additional Notes:

DIETICIAN
Maximum ($) coverage per benefit year? ______________
% of coverage per visit? ______________
Reasonable and necessary per visit? ______________
Medical doctors referral needed? ☐Yes ☐No
Additional Notes:

PSYCHOLOGICAL COUNSELING
Maximum ($) coverage per benefit year? ______________
% of coverage per visit? ______________
Medical doctors referral needed? ☐Yes ☐No
Who can provide service?
☐ Social Worker: if yes, Reasonable and necessary per visit? __________
☐ Psychologist: if yes, Reasonable and necessary per visit? __________
☐ Psychiatrist: if yes, Reasonable and necessary per visit? __________
☐ Counsellor: if yes, Reasonable and necessary per visit? __________

Patient Name: ___________________________________

CUSTOM ORTHOTICS

Maximum ($) coverage per benefit year? ______________
% of coverage per pair? ______________
What is the eligibility for pair renewal?

- ❏ 1 per year
- ❏ 1 per 2 years
- ❏ 1 per 3 years
- ❏ Other: ______________________

Who can refer?

- ❏ Medical doctor
- ❏ Podiatrist
- ❏ Chiropodist
- ❏ Chiropractor

Can it be dispensed by a chiropractor?

What is required for claim submission?

- ❏ 3D Scan
- ❏ 2D Scan
- ❏ Biomechanical Analysis & Gait Analysis
- ❏ Casting Technique
- ❏ Raw Materials

Additional Notes:

COMPRESSION STOCKINGS

Maximum ($) coverage per benefit year? ______________
% of coverage per pair? ______________
Reasonable and necessary per pair? ______________
How many pairs per year? ______________
What is the compression factor eligible for reimbursement?
(e.g. 20-30 mmHg) ____________
Medical doctors referral needed?

- ❏ Yes
- ❏ No

Additional Notes:

TENS MACHINE

Maximum ($) coverage per benefit year? ______________
% of coverage for device? ______________
Reasonable and necessary for device? ______________
Medical doctors referral needed?

- ❏ Yes
- ❏ No

Does the condition need to be chronic?

- ❏ Yes
- ❏ No

Additional Notes:

ORTHOPAEDIC BRACES (BACK, WRIST, KNEE, ELBOW, ANKLE)

Maximum ($) coverage per benefit year? ______________
% of coverage per brace? ______________
Reasonable and necessary per brace? ______________
Medical doctors referral needed?

- ❏ Yes
- ❏ No

Additional Notes:

PILLOW

Maximum ($) coverage per benefit year? ______________
% of coverage per pillow? ______________
Reasonable and necessary per pillow? ______________
Medical doctors referral needed?

- ❏ Yes
- ❏ No

Additional Notes:

I confirm that all the information above is accurate and that I have advised the clinic if any amount was used at another clinic in the current benefit year. It is my responsibility to make sure the amount of coverage being used is within my policy limit and that if the extended healthcare company does not pay for any visits, the payments are to be made by me directly to Intelligent Health Group for the services rendered and/or products and devices provided.

Patient Signature: ____ **Date:** ______________________________________

Patients Name: ______________________________

OFFICE POLICIES

1. If you ever wish to change your health goal, or associated treatment frequency, you are required to speak to your health professional directly. Our administrators are unable to make changes to your plan as it may affect your health negatively.
2. Our office is dedicated to nurturing a safe, healing environment. As such, any rude, inappropriate, discriminatory, intolerant behavior or language will not be accepted, and as such, may lead to termination of care at our office.
3. Payments for treatments are to be rendered at the end of each session, or prepaid through a payment plan. Unpaid outstanding balances over 30 days past due can be sent to a Collections agency for recovery of payment. Prepaid payment plans may be cancelled at anytime. A refund will be issued based on a re-calculation of the treatments completed at full cost.
4. Direct billing to *only your primary* insurance provider can be arranged, as long as the payments are directly paid to the clinic, and our *Extended Health Benefits Form* has been completed. It is required that *claim forms, Consent form*, and an *Assignment of Benefits Form* are signed and kept on record. Co-pay amounts not covered by your insurer must be paid at the time of service. You are required to keep track of your insurance coverage directly.
5. Our office respects each patient's right to privacy and keeps personal information confidential, unless required by law or in the case of a medical emergency. Patient files will remain in our stewardship for a minimum of 7 years after the last patient visit.
7. Our office may give appointment reminder calls, recalls, and reassurance calls. If you do not wish to receive any of these notifications please inform our front desk.
8. If you are unable to keep an appointment, simply call or email us at least **24 hours prior** to your appointment to reschedule. Missed appointments, late cancellations or arrivals will result in a charge for the full appointment fee. Please be advised that your insurance provider, or payment plan, will not cover such fees.

Your signature below confirms that you have reviewed all of these policies, and have had an opportunity to discuss them.

Patient's Signature: ___________________________________ **Date:** ___________________________________