Insurance Payment Waiver

I, ____, choose to waive coverage and payment responsibility by my insurance carrier for the "Affinity" services and supplies provided by the licensed physicians and professional staff at Bear Creek Naturopathic Clinic, LLC. As outlined by contract agreement "Affinity Services" includes but is not limited to:

> ' All dispensary items, Homeopathic and Methylation consultations, spinal manipulation and associated procedures, laboratory service fees, physical medicine, supplements, herbs and herbal products, ozone products and therapies, injection therapies, intravenous therapy, and educational materials that the Provider is licensed to provide or dispense and that ***may be covered*** under the client health benefit program".

In Summary, patient consents to waive any billing for "Affinity Services".

Patient Name: ___________________________________ Date: __________________________

Policy Holder Name:____

Patient/Responsible Party
Signature____

Insurance Co: ___________________________________ ID#: ___________________________

Witness: _______________________________________ Date: __________________________

Your Path Toward Health

Insurance Assignment of Benefits

Patient: ____

I.D. No: ____

Employer: ____

Group/Claim No: ____

I hereby instruct and direct ___________________________ Insurance Company to pay by check made out and mailed to:

Bear Creek Naturopathic Clinic
2612 E Barnett Road
Medford, OR. 97504

for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of the Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Patient Name:____

Policy Holder Name:____

Responsible Party Signature:____

Date: ____________________

(For Office Use Only) Witness: ____

How do I check my insurance benefits?

(We cannot accept Medicare, Medicare Advantage, CCOs, Medicaid, OHP.)

Patient Name___________________________ **Patient phone #** _________________ **DOB** ____________
Insurance Company _____________________ **Insurance ID#** __________________ **Group** __________
Group # _______________________________ **Eligibility/Claims phone #** _________________________

It is the patient's responsibility to be aware of her/his coverage and co-pay, as well as any deductible and maximums. Bear Creek Naturopathic Clinic does bill some insurances depending on the doctor you are seeing, and if you have naturopathic benefits. We also can provide a superbill to patients billing their own insurance.

First, *Call the number* on your insurance card listed for customer service, benefits and eligibility, or subscriber services and ask the representative the following questions:

1. When did my *coverage begin and when is it valid thru*?
Beginning Date of Coverage_________ **Ending Date of Coverage**____________

2. Do I need *a referral from my primary care physician* (PCP) for alternative services?
___**Yes** ___**No**

3. Is the doctor I want to see *In-Network or a preferred provider, or is Out-of-Network* with my insurance? (Dr. Tichauer will always be out-of-network). NOTE: Services by an in-network provider may still not be covered under the terms of your specific policy. **(See #4.)**
___**Yes** ___**No**

4. What are my *specific benefits* for the following services with this Provider? *Benefits vary depending on policy type and in/out-of-network status.*

Naturopathic: % Covered_______; Co-pay/ Co-Insurance______; Year Max_____
Please ask if the following codes are covered by your plan AND choice of Provider:
CPT 99205 (New Patient Visit) _______
CPT 99354 (New Patient Visit, Extended) _______
CPT 99215 (example Return Patient Visit) _______

Labs: % Covered_______; Co-pay/ Co-Insurance______;Year Max________

My labs are: ____ Covered; _____ Not Covered when ordered by Dr_________________.

5. Is there a copay per **visit** or per **specialty**? Please circle which one. **Copay amount ______**

6. What is my *deductible for the year* and has any or all of it been met?

In-Network Deductible $ _______. Amount of Deductible met so far $________ Date______
Out-of-Network Deductible $_______. Amount of Deductible met so far $________ Date______
In what month of the year does my deductible start over? _________________
Are any of the specialties listed above **subject to this deductible**? ____**Yes** ____**No**
If so, **which specialties**? ____

7. What was the *name of the representative* I spoke with? _____________________ **Date**_________

Please bring this form with you to your appointment. If you have trouble getting the information you need, please feel free to call the clinic for assistance. Thanks so much!
**Please be aware that this is not a guarantee of payment. If an insurance company gives you inaccurate information they may not honor the benefits that were quoted.