INSURANCE BENEFIT ACKNOWLEDGEMENT FORM

PATIENT NAME: _____

INSURANCE: _____

ANNUAL DEDUCTIBLE: _____
(PATIENT RESPONSIBILITY)

BEFEFITS: _____
(AMOUNT INS PAYS AFTER DEDUCTABLE HAS BEEN MET)

PATIENT RESPONSIBILITY: _____
(AFTER DEDUCTABLE IS MET)

LIMITATIONS: _____
(HOW MANY VISITS ALLOWED / NUMBER USED)

REFERRAL NEEDED: YES ☐ NO ☐ COPAY: YES ☐ NO ☐

PRE-AUTHORIZATION: YES ☐ NO ☐ AMOUNT: $_____

Disclaimer: This quote is not a Guarantee of payment. Benefits, if any will be assessed by your insurance plan carrier upon receipt of claims and are subject to eligibility, and based on plan provisions and limitations in effect at the time of services are rendered.

By signing below you acknowledge that you understand this disclaimer and agree to pay any and all patient responsibility as determined by your insurance plan carrier.

X_____ _____
SIGNITURE OF PATIENT OR LEGAL GUARDIAN **DATE**