Insurance information and consent form

Currently we offer direct billing with:

Pacific Blue Cross / Great-West Life / Canada Life / Sunlife / Manulife / Greenshield / Johnson / Maximum Benefit / iA financial / Johnston Group / Chambers of Commerce / ICBC

Services we can direct bill for: Massage Therapy, Physiotherapy, Chiropractic Care, Acupuncture, Registered Dietician and Naturopathic care

Patient information:

First Name: _____ Last name: _____

Date of Birth (yyyy/mm/dd): _____ Gender: _____

Primary Coverage Information:

Relationship to member with the primary coverage: _____

Primary Members First Name: _____ Primary Members Last Name: _____

Primary Members Birth Date (yyyy/mm/dd): _____

Insurance Company: _____ Policy#: _____ Member ID: _____

ICBC Information:

Claim #: _____ Accident Date: _____

- We only bill to ICBC for accidents within 12 weeks of the appointment or with an approved treatment plan. Please discuss with our front end staff if you are unsure whether or not you qualify

Please note:

1. At this time we can only direct bill to your primary plan.
2. Not all insurance policies allow payments to be sent to the clinic, in which case we cannot direct bill and the patient must pay for their appointment at the time of service.
3. Some claim submissions require additional processing by the Insurance Company in which case we are unable to direct bill and patients must pay for their appointment at the time of service.
4. We do not have access to plan details. Any questions as so the plan must be directed to the insurance company itself.

Consent:

I hereby assign benefits payable for the eligible claims to the Provider responsible for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to the Provider, Acacia Health. In the event my claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to the Provider for any services rendered.

I acknowledge and agree that the insurer/plan administrator is under no obligation to accept this assignment, that any benefit payment made in accordance to this assignment will discharge the insurer/plan administrator of its obligations with respect to that benefit payment, and that in the event the benefit payment is made to me, the insurer/plan administrator will also be discharged of its obligation with respect to that benefit payment.

I understand that this assignment will apply to all eligible claims submitted electronically by the Provider and that I may revoke it at any time by providing written notice to the insurer / plan administrator. If I am a spouse or dependent, I confirm that I am authorized by the plan member to execute an assignment of benefit payments to the Provider.

Date: _____
Signature: _____
Print name: _____