A Total Approach to Health and Wellness

INSURANCE INFORMATION

Many patients have private health care plans either through their work or through their spouse's (or common law). Most of these plans cover chiropractic, physiotherapy, massage therapy, acupuncture, naturopathy, psychology, and orthotics. Insurance information is confidential and only YOU can request it from your Insurance Company, which is why we need you to fill out this form. The form below will help you collect this information. **This form must be fully filled out before any direct billing occurs.**

Patient's Name: _____ Insured's Name: _____

Relationship to patient: _____ Insured's Date of Birth (DD/MM/YYYY) _____

Insurance Company: _____ Benefit Year: _____ (Month) ~_____ (Month)

Plan Number*: _____ ID Number*: _____

**Insurance Companies often have different identification numbers that they use to determine who the insured is and how they refer to these is different from company to company.

Is Direct Billing Allowed? ☐YES ☐NO Photocopy of Benefit Card Provided: ☐YES ☐NO

	Chiropractic	Physiotherapy	Massage	Acupuncture	Naturopathy	Psychology	Orthotics
Deductible:							
$ Per year:							
$ or % Per visit:							
MD Prescription Required?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No

Direct billing is a courtesy. Should your claim not be covered for ANY reason including errors and omissions by Optimum Wellness Centres, you are ultimately responsible for any charges incurred.

Please initial here ⇒ ☐

Consent to Collect and Exchange Personal Information

Personal information that we collect and disclose about you, and if applicable, your spouse and/or dependents, is used by the insurer and/or plan administrator and their service provider(s) for the purposes of assessing your claims, underwriting, investigating, auditing and administering the group benefits plan, including the investigation of fraud and / or plan abuse.

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. 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 and/ or supplies provided.

Please initial here ⇒ ☐

I acknowledge and agree that the insurer/plan administrator is under no obligation to accept this Assignment, that any benefit payment made in accordance with 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.

Please initial here ⇒ ☐

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.

Please initial here ⇒ ☐

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.

Please initial here ⇒ ☐

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Authorization and Consent

I authorize my healthcare provider to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer and/or plan administrator and their service provider(s) for the above purposes.

I authorize the insurer and / or plan administrator and their service provider(s) to:

- Use my personal information for the above purposes.
- Exchange personal information with any individual or organization, including healthcare professionals, investigative agencies, insurers and reinsurers, and administrators of government benefits or other benefits programs when relevant for the above purposes.
- Exchange personal information concerning any claims submitted with the plan member or a person acting on behalf of the plan member.
- Exchange personal information for the above purposes electronically or in any other manner.

I understand that personal information may be subject to disclosure to those authorized under applicable law.
I agree that a photocopy or electronic version of this authorization shall be as valid as the original, and may remain in effect for the continued administration of the group benefits plan.

Please initial here ⇒ ☐

Electronic Transmission Authorization and Consent - Additional Consent Applicable to Plan Members Only

I confirm that I am authorized by my spouse and/or dependents, if any, to disclose personal information about them to the insurer and/or plan administrator and their service provider(s) for the purposes described above and I confirm that my spouse and/or dependents also authorize the insurer and/or plan administrator and their service provider(s) to disclose information about their claims to me, for the purposes of assessing and paying a benefit, if any, and managing the group benefits plan. I also authorize my spouse and/or dependents to assign benefit payments under the plan to the healthcare provider.

In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning claims submitted, I acknowledge and agree that the insurer and/or plan administrator and their service provider(s) may use and disclose relevant personal information to any relevant organization including law enforcement bodies, regulatory bodies, government organizations, medical suppliers and other insurers, and where applicable my Plan Sponsor, for the purposes of investigation and prevention of fraud and/or plan abuse.

If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable under the group benefits plan, and the exchange of personal information with other persons or organizations, including credit agencies and, where applicable, my Plan Sponsor, for that purpose.

I have read the above and understand the contents.

Dated this _____ day of _____, 20____

Patient Name	Patient Signature
Plan Member Name	Plan Member Signature
Witness Name	Witness Signature

INSURANCE INFORMATION