Natural Health Center, LLC
compassionate care changing lives

3330 EAGLE STREET ANCHORAGE, AK 99503
T (907) 561-2330 F (907) 561-1282

Insurance Billing Practices:

Natural Health Center, LLC does not verify your insurance benefits. Please call your insurance company and fill out the attached Benefit Verification Form for each insurance policy you would like us to bill and bring to your initial appointment with your patient registration. If the Benefit Verification Form is not completed and provided upon check-in, you will be required to pay cash for your services.

As a courtesy to you, Natural Health Center, LLC will bill your insurance policy or policies for covered services only. If Naturopathic/ Acupuncture is not a covered benefit under your policy we will not courtesy bill for these services Certain exceptions may apply, such as needing the denial from your primary insurance to bill your secondary insurance.

Commercial Insurance:

Currently we have three providers who are contracted with Blue Cross Blue Shield.
Rick Abbott, DC - Chiropractor
Birgit Lenger, ND - Naturopathic Doctor
Laura Croix, PT – Physical Therapist

Federal Government Insurance: Naturopathic Providers are not covered.

Medicare/Medicaid/GEHA/Federal Blue Cross/Tricare/VA/Mailhandlers

We do have denials on file from Medicare for Naturopathic/Acupuncture services so if you have a secondary policy, not supplemental, they may be covered. Some secondary policies that have been billed and have accepted these denials for Naturopathic services are: Wells Fargo (Alaska Care), Blue Cross, Aetna, EBMS, ASEA, and IBEW. Wells Fargo and ASEA ***do not cover*** *Acupuncture services.*

At this time we are not accepting any new Medicare patient's for Dr. Abbott or Laura Croix, PT.

Workers' Compensation/Personal Injury:

There are separate Benefit Verification Forms online for Workers' Compensation or Personal Injury; again you will have to provide this information with your completed paperwork upon check-in.

If you are being treated for a Workers' Compensation claim you must be seen by Dr. Abbott first. He will be able to refer you to see a Naturopathic/Acupuncture provider if it is appropriate.

We do not bill 3rd party auto insurance. If you are in an auto accident we will ***only*** *bill your auto insurance policy.*

At Natural Health Center, LLC we make every effort to collect insurance portions due from your insurance company before we transfer the balance to your responsibility. Sometimes we require your help with this process. This includes submitting appeals on your behalf when a "Non-covered" provider denial is received and you have verified via your Benefit Verification form they were a covered provider.

If Insurance requests information from you to process claims, we will give you a written notification that the information is needed and a two week grace period to follow up with your insurance to provide that information to them. If after this time the information is not returned or being followed up on, the balance will be transferred to you and any future services you may have at the clinic will need to be paid for in cash at the time of service.

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Motor Vehicle Verification

1. Patient Name _____
2. Patient's SSN _____ DOB _____
3. Date of accident _____ State of Accident _____
4. Insured Name _____
5. Insurance Co _____
6. Billing Address _____
7. Ins Co Phone # _____
8. Ins Co Fax # _____
9. Claim # _____
10. Max Benefits _____
11. Benefits used to date _____
12. Body Part injured _____
13. Adjustors Name _____
14. Spoke to _____
15. Verified by _____ Date _____
16. Open claim _____
17. Is claim in litigation? _____
18. How many other providers is patient seeing? _____
19. What other charges/claims are currently being processed on this claim?_____

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DOCTOR'S LIEN

TO: Insurance Carrier / Attorney

_____
Insurance / Attorney Name

_____
Billing Address

_____
City/State Zip Code

DOCTOR: _____

RE: Patient Records and Doctor's Lien

I DO HEREBY AUTHORIZE the above doctor to furnish you, my insurance carrier/attorney, with information regarding my history, examination, diagnosis, treatment and prognosis of myself with regard to my accident/injury which occurred/began on ____/____/____.

I do hereby give a lien to the above mentioned doctor on any settlement, claim, judgment, or verdict as a result of said accident/illness, and authorize and direct you, my insurance carrier/attorney, to pay directly to said doctor such sums as may be due and owing for services rendered to me.

I fully understand that I am directly responsible to said doctor for all bills submitted for services rendered to me, and that this agreement is made solely for said doctor's additional protection and in consideration of awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover.

Dated: ____/____/____ Patient's Signature: _____

INSURANCE CARRIER / ATTORNEY ACKNOWLEDGEMENT OF DOCTOR'S LIEN

The undersigned, being attorney of record or authorized representative of insurance carrier for the above patient, does acknowledge receipt of the above lien, and does agree to honor the same to protect said above named doctor.

Dated: ____/____/____ Authorized Signature: _____

*** Please date, sign and return to doctor's office at once. Keep one copy for your records.

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FINANCIAL POLICY:
AUTOMOBILE/PERSONAL INJURY

1. Our office will accept your insurance assignment, along with a signed Doctor's Lien and Notice to Insurance Company of Assignment. This is a courtesy we offer to our patients. The patient is responsible for all fees from professional services rendered regardless of insurance coverage.

2. If you (the patient) have either personal or automobile insurance, we will file this claim under one of these policies. We do not file to third party insurance. At the time your claim is settled, any other insurance carriers/attorneys involved with your claim may settle up between themselves.

3. If your claim goes to trial, we will accept a Doctor's Lien and an Acknowledgement of Assignment on your behalf to be filed to your (the patient's) attorney. If your claim is not settled before one (1) year from the original date of treatment, your (the patient's) account balance must be paid in full. Personal injury claims are not carried for longer than one (1) year unless prior authorization has been obtained from the doctor.

4. This policy is valid only for the duration of your actual care/treatment at our clinic. If you discontinue your care/treatment at the Natural Health Center without the doctor's prior authorization, the balance of your account will become due and payable in full.

5. An account is past due if there are charges or a balance unpaid 60 days from the date of service without prior arrangements being made. Past due balances are subject to a Finance Charge equal to actual collection costs plus the current Alaska legal rate of interest. At our sole discretion, accounts with past due balances older than 120 days may be reported to The Credit Bureau, Inc. and/or seek court action.

IF YOU HAVE READ, UNDERSTAND AND AGREE WITH ALL OF THE ABOVE OFFICE POLICIES - PLEASE SIGN AND DATE BELOW.

Dated: _____/_____/_____ Patient's Signature: _____

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NOTICE TO INSURANCE COMPANY OF ASSIGNMENT

TO: Insurance Carrier

_____
Insurance / Attorney Name

_____
Billing Address

_____
City/State Zip Code

You are instructed to pay direct to the doctor at his/her office for all professional services rendered to me.

This instruction to you is an **ASSIGNMENT OF RIGHTS** under my medical coverage to the extent of this bill.

Any sum of money paid under this assignment shall be credited to my account and I shall be personally liable for any unpaid balance.

Pay to Doctor: _____

Dated: _____/_____/_____

_____
Patient's Signature

_____
Print Patient's Name

_____
Patient's Address

_____
City/State Zip Code

ACKNOWLEDGEMENT OF INSURANCE COMPANY

This insurance company hereby acknowledges receipt of the above **ASSIGNMENT OF BENEFITS** and agrees to forward payment of medical services rendered. Payment will be sent to the office of and to the order of the doctor only.

Dated: _____/_____/_____ Authorized Signature: _____

***** Please date, sign and return to doctor's office at once. Keep one copy for your records.**

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Patient's Name _____ Date ____/____/____

PERSONAL INJURY – PATIENT DATA FORM

Accident Information

Date of accident: __/____/____ Time: _____(AM / PM)

Number of people involved: _____ Number of cars involved: _____

Location (ADDRESS IF POSSIBLE): _____

Closest bisecting street/town: _____

Vehicle Information

Were you driving or a passenger? _____ Were you seated? _____

Were seatbelts worn?_____ Were shoulder harnesses worn? _____ Does vehicle have headrests? _____

If yes, what was the position of those headrests compared to your head before the accident?

( )Top of headrest even with bottom of head
( )Top of headrest even with top of head
( )Top of headrest even with middle of neck

Who owns the vehicle? _____ Year and model of car: _____

What was the approximate damage done to the vehicle? $_____

Driving Conditions

Visibility at the time of accident (circle one): Poor Fair Good Other: _____

Road conditions at the time of accident: Icy Rainy & Wet Clear Dark Other: _____

Point of Impact

Where was the car struck (circle one): Right side Left side Rear Front Car rolled

Other: _____

Type of accident:
( )Head-on collision ( )Broad-side collision
( )Rear-end collision ( )Front impact, rear-ended car in front
( )Non-collision (describe): _____

Accident Description

Describe in your own words what happened to you upon impact: _____

_____

_____

Did you see the accident coming? Yes / No
Did you brace for impact? Yes / No
Was your vehicle breaking? Yes / No

Was your vehicle moving at the time of accident? Yes / No If yes, how fast were you going? ____m.p.h. (est.)

How fast was the other vehicle traveling? _____m.p.h. (estimate)

Were you wearing glasses? Yes / No Did they come off as a result of the accident? Yes / No

Body Injury

Body position at time of impact: ( ) head turned left / right ( ) body straight in sitting position
( ) looking back ( ) body rotated left / right
( ) head straight ( ) other: _____

At the time of accident, recall what parts of your head or body hit what parts on the inside of the vehicle:

_____

Upon impact, was there a blinding or explosive sensation in your head? Yes / No

As a result of the accident were you:
( ) rendered unconscious ( ) dazed, circumstances vague ( ) other: _____

Could you move all parts of your body? Yes / No If no, what parts and why?

_____

Were you able to get out of the car and walk un-aided? Yes / No If no, why not?

_____

Describe how you felt immediately after the accident. Please be specific. _____

_____

Did you get bleeding cuts from this accident? Yes / No If yes, where? _____

Did you get bruises from this accident? Yes / No If yes, where? _____

Check symptoms apparent since the accident:

( ) Headache	( ) Loss of smell	( ) Numbness in fingers
( ) Neck pain / stiffness	( ) Loss of taste	( ) Cold hands
( ) Mid back pain	( ) Loss of memory	( ) Cold feet
( ) Low back pain	( ) Fatigue	( ) Diarrhea
( ) Eyes sensitive to light	( ) Tension	( ) Constipation
( ) Pain behind eyes	( ) Shortness of breath	( ) Chest pain
( ) Dizziness	( ) Irritability	( ) Nervousness
( ) Fainting	( ) Depression	( ) Cold sweats
( ) Ringing / buzzing ears	( ) Sleeping problems	( ) Anxious
( ) Loss of balance	( ) Numbness in toes	( ) Other _____

Employment

Occupation: _____ Employer: _____

Have you missed time from work? Yes / No

If yes,

Full time off work _____to_____ : _____to_____

Part time off work _____to_____ : _____to_____

( ) Unable to work since accident

Medical History

Did you go to seek medical help? Yes / No If yes, when?_____

If yes, how did you get there? ( ) Someone else drove my car ( ) Ambulance
( ) Drove my own car ( ) Police
( ) Other

1st doctor seen: _____ Hospital/Clinic Name: _____

Date seen: ___/_____/___

Were you examined? Yes / No Were X-rays taken? Yes / No

What treatment was given to you? ( )bed rest ( )brace ( )physiotherapy

( )adjustments ( )other:_____

Were you prescribed any drugs or medications? Yes / No If yes, list: _____

_____

Did you take them? Yes / No Were they effective? Yes / No

If no, why not? _____

Date of last treatment_____/_____/_____

2nd doctor seen: _____ Hospital/Clinic Name: _____

Date seen: ___/_____/___

Were you examined? Yes / No Were X-rays taken? Yes / No

What treatment was given to you? ( )bed rest ( )brace ( )physiotherapy

( )adjustments ( )other:_____

Were you prescribed any drugs or medications? Yes / No If yes, list: _____

Did you take them? Yes / No Were they effective? Yes / No

If no, why not? _____

Date of last treatment_____/_____/_____

Did you have any physical complaints BEFORE THIS ACCIDENT? Yes / No

If yes, please describe in detail: _____

_____

Prior to this accident, have you EVER had symptoms similar to what you're experiencing now?

Yes / No

If yes, please explain (briefly include past falls, injuries, accidents, operations, etc.): _____

_____

Do you notice any activities of your daily routines that are different now than before the accident?

Yes / No If yes, list them as:

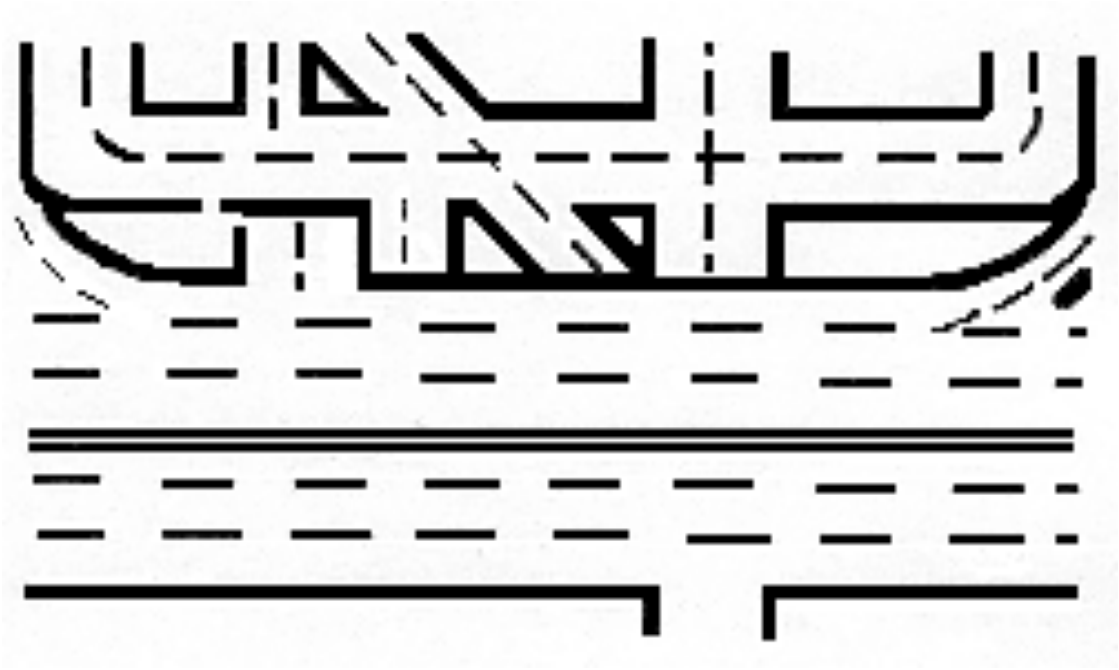
Those that you are unable to do are: _____

Those that are painful to do are: _____

Those that are difficult to do are: _____

Diagram

Indicate on this diagram how the accident occurred:



1) Patient's Insurance Company Information:

Company Name: _____ Phone: _____ Policy #_____

Billing Address: _____ Adjuster's Name: _____

City/State/Zip: _____

2) Insured's Insurance Information:

Insured's name (if other than patient): _____ Phone: _____

Company Name: _____ Phone: _____ Policy #_____

Billing Address: _____ Adjuster's Name: _____

City/State/Zip: _____

3) Other Driver's Insurance Information (if another car's driver was at fault):

Other Driver's Name: _____ Phone: _____

_____

Company Name: _____ Phone: _____ Policy #_____

Billing Address: _____ Adjuster's Name: _____

City/State/Zip: _____

I hereby state that the information on this form is true and correct. I authorize the Natural Health Center LLC. to examine, make x-rays, treat me and do whatever they deem necessary in accordance with the state statutes, for the care and management of my condition. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Natural Health Center, LLC. will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Natural Health Center will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment at the Natural Health Center, LLC., any fees for professional services rendered to me will be immediately due and payable.

_____ _____/_____/_____

Patient's Signature Date

_____ _____/_____/_____

Parent, Legal Guardian or Spouse's Signature Date