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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Worker's Compensation Verification

Patient Name: _____

Patient's SSN: _____DOB: _____

Date of loss: _____

Insurance Co: _____

Claims Address: _____

Ins. Co. Phone #:_____

Ins. Co. Fax #: _____

Employer at Time of Injury: _____

_____

Claim #: _____

Body Site of Injury: _____

Adjuster Name: _____

Have there been any controversions on this claim? Y N

If yes, what was controverted? _____

_____

Spoke to: _____

Verified by: _____ Date: _____

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FINANCIAL POLICY:
WORKERS COMPENSATION

For those patients who have been injured on the job:

You are covered under the State of Alaska Workers Compensation Law. This law provides you with 100% chiropractic coverage for work related bodily injuries.

Our office will submit the medical injury forms and submit all bills directly to the insurance carrier of your employer.

However, in order for us to ensure effective coverage, you must do the following:

1) Report the injury to your supervisor immediately.
2) Fill out an employee work injury form and turn it in to your employer.
3) Fill out the top two sections of the Physicians Report form we present to you. This must be completed at our office to ensure that we submit this in a timely manner.
4) Read carefully the pamphlet **WORKERS COMPENSATION: THE BASIC FACTS FOR EMPLOYEES**. Your understanding of what your legal rights are in regard to your injury will enable us to all work together to get you better and back to work.

By my signature, I clearly understand and agree that I am ultimately responsible for all services rendered to me.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

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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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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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WORKER'S COMPENSATION HISTORY

PREVIOUS WORK HISTORY:

Gain a detailed description of services or work performed for each source of employment for the preceding 10 years. _____
_____
_____
_____

Was a pre-employment exam performed or required? __ Yes __ No
Date: _____ Doctor: _____ Place: _____

Have you ever applied for worker's compensation benefits before? __ Yes __ No
Date: _____ Reason: _____

What was the time loss from work? _____
State the degree of recovery for each: _____
_____

Have you retained any legal counsel for this injury? __ Yes __ No For previous injury? __ Yes __ No

PRESENT INJURY:

Date present injury was received: _____
What is job classification of normal job? _____
Were you doing a normal job duty? _____
How long have you been at present job? _____
What shift were you working? _____
Time of accident? _____
Were you on overtime? __ Yes __ No
Average work week? Hours: _____ Days: _____
Who saw the accident? Name: _____ Title: _____
Name: _____ Title: _____
Who reported the accident? Name: _____ Title: _____
Name: _____ Title: _____

What medical attention was rendered? _____
By whom? __ Nurse: _____ __ M.D.: _____
__ D.O.: _____ __ D.C.: _____
__ Other employee: _____ __ Other: _____

INJURY DESCRIPTION:

How did the injury occur? _____
Chief complaints: Symptoms: _____
_____

If working on a machine, give the size: _____ Height, weight, length: _____
Foot or hand levers? _____ Did you work overhead? ____ Straight on or under? _____
Movements on the job – were they to the right, left, up, down, under, over? _____
_____

Do you pick up or lift? ____ If you lift, how much? _____ How often do you lift? _____
From where, in what, to where? _____
Do you lift from the ground, bench, platform? _____
Pallet, box or other? (Please describe) _____
Do you lift out of a machine? _____
If working at a machine do you: __ Sit __ Stand __ Kneel
If so, onto what? _____ Is the work area cluttered? _____
Is so, with what? _____
Is the work area? __ ½ Oily __ Dirty __ Slippery
In your job do you push or pull? _____ If yes, give specifics: _____
_____

Do you use a cart? __ Two-wheel __ Four wheel_____
Construction of cart: _____
Type of wheels? __Rubber __ Steel _ Plastic
Repair of cart: _____
Number of carts being pushed or pulled at one time? _____
The total amount of weight being pushed or pulled on a daily basis? _____

JOB CONDITIONS:

Type of building: _____
Type of floor : __ Rough __ Smooth __ Wood __ Concrete __ Steel
Type of windows: _____ Type of ventilating in the building: _____
Type of lighting in the building: _____
Are you tired when you go home at night? _____

Do you have outside jobs? _____
Do you participate in any company sponsored programs such as exercise, sports, etc.?
_____
Is it a union shop or a non-union shop? _____
Have you had to hire outside help? _____
Example: Cleaning, grass cutting, maintenance, etc.? _____

How many employees in the plant? _____
How many employees per shift? _____
How many other employees do your job? _____
What is the injury ratio for that job? _____ Do you like your job? _____
If off work, do you want to return to your job? _____
What change would you make in your job? _____

OFFICE WORK:

Sit at desk _____, walk _____, stand _____, other _____
What % _____, _____, _____, _____
Stand, stoop, hold, carry: _____
Operate other machine _____ What type? _____