

**PATIENT RESPONSIBILITY AND INSURANCE BENEFITS DISCLOSURE**

Vital Kids Medicine PLLC (VKM) understands that it can be difficult to determine the scope of your insurance plan and that insurance may not always cover all of our services. The purpose of this form is to help you fully understand your health insurance package and enable you to get the most from it. While it is **NOT REQUIRED** that you fill out this form, we strongly recommend that you have a complete understanding of your specific insurance plan and benefits.

Some policies have a deductible, this is the amount of money you pay on a claim (or claims) before your insurance begins paying. Some have in-network benefits that are covered at a higher percentage than out of network benefits (which may have a substantial deductible).

Because VKM wants your treatment to be as stress-free as possible and for you to be **fully informed** of your coverage, we highly recommend that you call your insurance company and use this outline to fully understand your particular insurance plan and benefits.

We appreciate your time and thank you for your cooperation.

Insurance Company and Plan Name:		
Insurance Address:		
Insurance Phone:		
Name of Policy Holder:	Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Prefix:	ID Number:	Group/ Policy number:
<b>Copay: \$</b>	<b>Effective Date:</b>	
<b>Do I have a deductible:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	If Yes, what is it? How much has been met?	
Do I have out-of-network benefits: <input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, what is the percentage that is covered for out of network providers:	
Do I have Co-Insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO	If Yes, what is my max?	
Insurance verification representative (who you speak with to verify):		

<b>Naturopathic benefits</b>		
Am I covered for naturopathic benefits?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
What percent does insurance cover?		
What percent am I responsible for?		
Is a referral required?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Do I have a co-pay?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, what is my copay:
Are my naturopathic benefits subject to my deductible?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, what is my deductible:
Do I have preventative care coverage?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Does this include routine lab work with "V" codes?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Am I covered for prolonged visit codes?	<input type="checkbox"/> YES <input type="checkbox"/> NO	

Are there any exclusions?	<input type="checkbox"/> YES <input type="checkbox"/> NO
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<b>Diagnostic Testing Benefits:</b>		
Am I covered for diagnostic testing?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
What percent does insurance cover?		
What percent am I responsible for?		
Is a referral required?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Are labs subject to my deductible?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Has my deductible been met?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If Yes, how much?
Are there any restrictions for testing?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If Yes, what are they?
Are there any exclusions?	<input type="checkbox"/> YES <input type="checkbox"/> NO	

<b>Massage/ Manual Therapy Benefits:</b>		
Am I covered for manual therapy?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
What percent does insurance cover?		
What percent am I responsible for?		
Is a referral required?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Is manual therapy/ massage subject to my deductible?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Has my deductible been met?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If Yes, how much?
Are there any restrictions for manual therapy?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If Yes, what are they?
Are there any exclusions?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
How many visits per year am I covered?		

<b>Nutrition counseling/dietary education:</b>		
Am I covered for nutritional counseling (regular visits with the nutritionist)?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
What percent does insurance cover?		
What percent am I responsible for?		
Is a referral required?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Is nutritional counseling subject to my deductible?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Has my deductible been met?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If Yes, how much?
Are there any restrictions for nutritional counseling?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If Yes, what are they?
Are there any exclusions?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
How many visits per year am I covered?		