# *Optimal Family Chiropractic, LLC*

Dr. Brenda L. Rooney

## Insurance Questionnaire

22 Plaza Rd. Flanders, NJ 07836
Phone #: (973) 584-4888

*The following questions are necessary so that we may properly file your insurance for you. These questions are taken directly from the insurance form that we must fill out and file for you. Please answer as fully as possible.*

1. Type of insurance: ☐ Medicare, ☐ Medicaid, ☐ Group Health Plan, ☐Other: _____,
   Insured's ID #:_____
2. Patient Name: _____
3. Insured's Name (as it appears on the insurance card):_____
   **Patient's Address**: _____
   City:_____, State:_____, Zip:_____, Home #: _____-_____-_____
   Cell Tel #:_____-_____-_____.
5. **Insured's Address** (if same as patient put "same"):_____
   City: _____, State: _____, Zip: _____, Home #: _____-_____-_____
   Cell Tel #:_____-_____-_____
6. Patient Status: □ Single, □ Married, □ Other, □ Employed, □ Full-time Student, □ Part-time Student
7. Other Insured's Name (if applicable):_____
   Other Insured's Policy or Group Number: _____
   Other Insured's Date of Birth: _____/_____/_____, □ Male, □ Female
   Employer's Name or School Name: _____
   Insurance Plan Name or Program Name: _____
8. Is the condition we are treating related to current or previous employment? □ Yes/□ No.
9. Is the condition we are treating related to an auto accident? □ Yes/□ No.
10. Is the condition we are treating related to another type of accident? □ Yes/□ No.
11. Insured's Policy Group or FECA Number: _____
    Insured's Date of Birth: _____/_____/_____, □ Male, □ Female
    Employer Name or School Name: _____
    Insurance Plan Name or Program Name: _____
12. Is there another health benefit plan? □ Yes/□ No

*Patient's or Authorized Person's Signature*: I authorize the release of any medical or other information necessary to process my insurance claim. This is to serve as a long-term authorization card.
Signed: _____, Date: _____/_____/_____

*Insured's or Authorized Person's Signature*: I authorize payment of medical benefits to Optimal Family Chiropractic for the services described on the insurance form. This authorization is to apply to all occasions of service until it is revoked in writing. I agree to pay for services not covered by insurance and understand that I am ultimately responsible for payment in full at this office.

Signed: _____, Date: _____/_____/_____

### *MEDICARE ONLY*

*All doctors have been instructed to ask the following questions of all Medicare patients;*

1. Do you or your spouse work for a company that provides you with health insurance? □ Yes/□ No.
2. Are you entitled to Medicare because of End Stage Renal Disease? □ Yes/□ No.
3. Is the illness or injury the result of an accident or illness that occurred at work? □ Yes/□ No.
4. Is this illness or injury the result of an accident or other injury? □ Yes/□ No.
5. Has the treatment for this accident or illness been authorized by the Veteran's Administration? □ Yes/□ No.
6. Are you entitled to any benefits under the Federal Black Lung Program? □ Yes/□ No.
7. Do you have a Medicare Medigap Policy? □ Yes/□ No.

***Name of Medigap Insurance Company:*** _____
_____, and ***ID#:***_____

8. Do you have a Medicare Supplement Policy? (Policy provided by employer you retired from)? □ Yes/□ No.