Cloud Chiropractic Clinic Dr. Shannon Anhorn DC. Phone: 503) 660-8154 Email: Cloudchiro@gmail.com

**Insurance Information (if applicable)**

Patient Name: Date of Birth:

ID #: Group or Plan#:

Insurance Company:

Insurance Address:

Customer Service Phone #: Insurance Fax:

Primary Subscriber (if not Patient): Employer:

SSN of Insured: DOB of Insured:

Insured Relationship to Patient: Insured is: ☐ Male ☐ Female

**Please call your insurance company to obtain the following information**

1. Beginning date of coverage: Ending date of coverage:

2. Does your plan have Chiropractic benefits? ☐ Yes ☐ No

3. If yes:

|  |  |  |
| --- | --- | --- |
|  | In- Network Benefits | Out-of Network Benefits |
| DeductibleAmount met so far |  |  |
| Co-pay/ Co-insurance amount |  |  |
| % Covered |  |  |
| Maximum coverage $ amount$ met so far |  |  |
| Maximum # visits per year# met so far |  |  |

4. Is there any coverage for ☐ Massage Therapy ☐ Acupuncture ☐ Naturopathy ☐ Physical Therapy

Notes:

5. Annual date of renewal:

6. Name of representative spoken with: Date: