Gray Chiropractic Health Clinic
Insurance Questionnaire

NOTE: Please write legibly. Misinterpretation of information could delay and/or deny coverage for the patient.

Insurance Company?_____

Complete Address:

Street_____

City_____ State_____ Zip_____

Phone#_____

Who did you talk to today? ID# or Call#_____

Policy ID# _____

Policy Group#_____

Effective Date of Policy? Is your plan a Fiscal or Calendar Plan?_____

Are there Chiropractic Benefits on your plan?_____

What is your deductible? How much has been met?_____

Is there a family deductible? How much has been met?_____

Is there an out of pocket maximum? Has it been met?_____

Is there a daily Co-Pay? What is it?_____

Is there a visit limit for chiropractic? How many are there? Have you used any?

YES NO #Visits per year_____ Visits Used_____

Are there limits on the following chiropractic services? If so how much?

- Examinations_____
- X-Rays_____
- Chiropractic Adjustments_____
- Physical Therapy_____
- Orthotics_____
- Massage Therapies_____
- Are Licensed massage Therapists covered under the direct supervision of the doctor?

  YES NO