Making the most of your health insurance starts here! Dr. Jessica Sweet, ND, LAc
1110 SE Alder St, Suite 201
503-477-5051

Insurance Benefits Verification

Patient Name: ____ **Date of birth:** ________________________
Address:____
City: ____ State: ____________ Zip: ____________________
Phone: ___________________________________ Relationship to insured: __________________________

Insured's Name (if different from the patient): ____
Date of birth: ___________________________________ Phone: _____________________________________
Address:____
City: ____ State: ____________ Zip: ____________________

Insurance Company: ____
Insurance ID #: ____
Group/Policy #:_______________________________________ Phone: _________________________________
Claims Address: ____
City: ____ State: ____________ Zip: ____________________

Call to verify your benefits and eligibility
1. To determine whether Dr. Sweet, ND, LAc is an in-network or an out-of-network provider with your insurance company, please call 503-477-5051 or email drjessicasweet@gmail.com to ask.

2. Next, call the number on your insurance card listed for customer service or benefits and eligibility. Ask the representative the following questions:

- **With whom am I speaking?** Name of the representative:____________________________
- **When did my coverage begin?** Date: ____________________________
- **What is my deductible and has any of it been met?** $____________/yr $_____________met
- **Is my deductible based on the calendar or fiscal year?** ____________________________
- **What is my co-pay/co-insurance and annual maximum for the following services:**

Naturopathic Office visit:	_______% Covered **or** $_________Co-pay	Year Max______________
Acupuncture:	_______% Covered **or** $_________Co-pay	Year Max______________
Lab Work:	_______% Covered **or** $_________Co-pay	Year Max______________

- **Do I need a referral or pre-authorization for any alternative services?**____________
- **Can my naturopathic doctor perform my annual physical and/or my gyn exams?** _____________

3. That's it! Feel more informed & empowered? We can go over this at your appointment if you have any additional questions.

ASSIGNMENT OF INSURANCE BENEFITS & VERIFICATION ACKNOWLEDGEMENT
I acknowledge the above listed coverage information is valid and correct. I understand that benefit verification is not a guarantee of coverage by my insurance company, and that I am financially responsible for all services rendered to me by Dr. Sweet, ND, LAc and Essential Family Medicine. I also understand that insurance billing provided on my behalf is a courtesy, and I authorize release of information in my medical history to my insurance company and assign all benefits for unpaid services to Dr. Sweet, ND, LAc.

Signature:____ Date: __________________________