Advanced Integrative Health Center

File Number:

Patient Information (Adult over 18)

Last Name:	First Name:		Middle Initial:
Date of Birth:	Age:	Social Security Number:	Gender: male: ☐ female: ☐
Street Address:			
City:		State:	Zip Code:
Home Phone #:	Work Phone #:	Cell Phone #:	
Name of Emergency Contact:	Phone Numbers & Address of Emergency Contact:		Relationship:

E-mail Address:_____ Referred by:_____

Insurance

Who is responsible for this account?_____

Will you be using health insurance to supplement payment to our office? Yes ☐ No ☐

If yes, please fill out the following:

Type of insurance (check all that apply):	☐ Employee group health plan	☐ Personal health insurance				
☐ Medical Savings Account	☐ Health Reimbursement Acct.	☐ Health Savings Acct.	☐ Flex Spend Account			
☐ Worker's compensation	☐ Personal Injury	☐ Medicare	☐ Medicaid	☐ TRICARE	☐ FEHBP	☐ IHS
☐ Health Maintenance Organization (HMO)	☐ Preferred Provider Organization (PPO)	☐ Point of Service Plan (POS)				

Primary Insurance Company:	Phone #	Effective Date:
ID #:	Group #:	
Secondary Insurance Company:	Phone #	Effective Date:
ID #:	Group #:	

Are the insured & the patient the same person? ☐Yes ☐No

If no, please fill out the following information about the insured:

Last Name:	First Name:		Middle Initial:
Date of Birth:	Age:	Social Security Number:	Gender: male: ☐ female: ☐
Street Address:			
City:		State:	Zip Code:
Home Phone #:	Work Phone #:	Cell Phone #:	
What is your relationship to the insured: Spouse: ☐	Dependent: ☐	Other: ☐ _____	

Health insurance plans are intended only to supplement out of pocket expenses for health care, please understand that that **your insurance may not cover all of the care that you need**. We will contact your insurance company to verify all of your insurance benefits & report the coverage back to you.

Our primary relationship is with you, the patient, not the insurance company. Given that we accept your case, our recommendations will be based upon what your needs are & what we believe is best for you.

I understand and agree to the following:
There is no guarantee that my health insurance plan or policy will pay for all or part of my care. As the patient or guardian of a patient, I am ultimately responsible for all charges incurred from services rendered at the Health Source Wellness Center.

Patient's signature (*or guardian's signature*):_____. Date:_____

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Is your visit as a result of an Auto Collision, Injury at Work, or a Personal Injury? ☐Yes ☐No

If yes, please fill out the following:

Is your claim through your insurance, or the other party?_____.

Name of the insurance company the claim is through?_____. Claim number?_____.

The claim adjuster's name, phone #, & address?_____.

Was a police report made? ☐No. ☐ Yes: what city/county?_____. Report #?_____.

Are you using an attorney for this case? ☐No. ☐ Yes: name & phone #?_____.

Benefits Assignment

I authorize that payment of charges be made directly to Dr. Luke Molitor of the Advanced Integrative Health Center. This authorization includes:

1. All insurance reimbursement for services rendered, including those which may be payable to me under my insurance plan or policy
2. Amounts owed on my behalf from proceeds of any settlement related to my case.

_____Patient's printed name (*or guardian's name*)

_____Patient's signature (*or guardian's signature*)

_____Date

Insurance Verification, For Office Use Only

Date of call: Time of call:

Contact name: Phone #:

Is this a **Workers' Comp** case? ☐Yes ☐No

Has the injury been reported? ☐Yes ☐No

Name:

Title:

Is patient currently employed at place of injury? ☐Yes ☐No

Name of person authorizing care:

Does the plan have a **deductible**? ☐Yes ☐No

Amount for an individual:

Amount for the family:

Amount currently met:

When does the deductible renew?

Do charges for diagnostic tests apply to the deductible? ☐Yes ☐No

Copayment / **coinsurance** after deductible is met:

What is the **maximum yearly benefit** ($)?

What is the **yearly visit cap** (# visits)?

Does the company assign benefits to the Dr? ☐Yes ☐No

Are any special forms required to file claims? ☐Yes ☐No ; if yes, explain:

Is this an **Auto Collision** or **Personal Injury** case?

Has it been reported to the ins. co.? ☐Yes ☐No

Has an app. for benefits been filed? ☐Yes ☐No

Did the police write a report? ☐Yes ☐No

Is auto or PI insurance primary? ☐Yes ☐No

Agent name and contact info:

Does the plan cover the following services?

New Patient Exams **(99201-5)**	☐Yes ☐No
Est. Patient Exams **(99211-5)**	☐Yes ☐No
Consultation Exams **(99243-5)**	☐Yes ☐No
Electrodiagnostic Studies **(95860-75, 95900-4)**	☐Yes ☐No
Labs **(36415-6, 99000, 81002, 81025-QW)**	☐Yes ☐No
X-rays **(Spine, Pelvis, UE, LE, Chest, KUB)**	☐Yes ☐No
Caloric testing w/o recording **(92533)**	☐Yes ☐No
Vest testing w/ recording **(92541-6)**	☐Yes ☐No
ECG & cardio stress **(93000,93005,93015,93017)**	☐Yes ☐No
Pulmonary studies **(94010, -060, -150, -200)**	☐Yes ☐No
Nutritional assessment **(97802-4)**	☐Yes ☐No
Muscle tests & ROM tests **(95831-4 & 95851-2)**	☐Yes ☐No
Hot/cold packs **(97010)**	☐Yes ☐No
Mechanical traction **(97012)**	☐Yes ☐No
Electric stimulation **(97014)**	☐Yes ☐No
Ultrasound **(97035)**	☐Yes ☐No
Ther. exercise **(97110)** & activities **(97530)**	☐Yes ☐No
Neuromuscular re-education **(97112)**	☐Yes ☐No
Manual therapy technique **(97140)**	☐Yes ☐No
Development of cognitive skills **(97532)**	☐Yes ☐No
Sensory integration technique **(97533)**	☐Yes ☐No
Biofeedback **(90901)**	☐Yes ☐No
ADL training **(97535)**	☐Yes ☐No
Cold laser (LLLT) **(97039 or S8948)**	☐Yes ☐No
Chiropractic Adjustments **(98940-3)**	☐Yes ☐No
Acupuncture **(97810-4)**	☐Yes ☐No
Massage Therapy **(97124)**	☐Yes ☐No
Gait training **(99216)**	☐Yes ☐No
Taping for immobilization/protection **(29200-80)**	☐Yes ☐No
Foot orthotic fitting **(97504)** & Supports **(L3020)**	☐Yes ☐No
Supports & Medical Equiptment	☐Yes ☐No

Today's Date: Monday, April 14, 2025.