

Verifying Your  
Insurance Coverage

Patient Name \_\_\_\_\_

**Austin Chiropractic Center**  
**Paul D. Austin, DC, CCSP, DACNB**  
**362 S. McCaslin Blvd., Louisville, CO 80027 Phone: 303-665-5405 Fax: 303-664-1697**

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Date \_\_\_\_\_ Time \_\_\_\_\_

Person you spoke to \_\_\_\_\_

Is Dr. Paul Austin an in-network provider for your carrier? Yes \_\_\_\_\_ No \_\_\_\_\_ (If "No," please call us to discuss Time of Service fees.)

What is my Chiropractic coverage and Limitations: I have a: -HRA -HSA and/or

Copayment amount per visit \$ \_\_\_\_\_ or

Calendar year Deductible \$ \_\_\_\_\_ Amt. of deductible met so far \$ \_\_\_\_\_

What percentage do I pay after the deductible has been met \_\_\_\_\_%

Yearly # of visits or limits to coverage \_\_\_\_\_

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Address to send claims to:


Please bring you Insurance card with you and we will place a photocopy of your card with this form in your chart.

Thank you,

Austin Chiropractic Center