Amber Wellness Group

1944 NE 45th Ave. Portland, OR 97213

Phone: 971.319.0045 Fax: 503.296.5712

Know before you go: Please verify benefits first and avoid surprises. Insurance companies can make changes at anytime without notifying members or providers.

Full payment is due at time of service. We do provide a 20% discount, for those without insurance or who choose not to file an insurance claim and pay out of pocket.

**Please note that you and/or your insurance company may be billed multiple procedure codes for a visit.

Insurance Company_____ Date Called_____
Representative's Name_____

Call the member services phone number on your insurance card and ask for a customer service representative (*automated services do not provide complete information) Have your ID # and Group # available (these are on the front of your insurance card).

1. Is my Naturopathic Primary Care Physician (ND) Dr. Lisa Dickinson and/or Dr. Meghan Bennett in-network? Yes/No- out-of network?

2. What is my in-network/out-of-network deductible? _____/_____

3. What is my co-pay/co-insurance for a naturopathic office visit? _____

4. Is there a max dollar amount for Naturopathic/Alternative Care for the year? _____ Max # of visits? _____

5. Is my Physical Therapy (CPT code 97140) covered? Yes/No
   Do I need pre-authorization? Yes/No
   What is co-pay/co-insurance? _____ Max # of visits? _____

6. Is Extended Time (CPT code 99354) covered? Yes/No
   What is the co-pay/co-insurance?
   _____

7. What is my responsibility for out-network lab/imaging tests?
   _____
   What is my responsibility for in-network lab/imaging tests?
   _____

8. Is there a preferred network lab/imaging lab? Yes/No
   (please circle one) Legacy Providence Quest OHSU
   Other_____

I understand that it is my sole responsibility to call my insurance company and find out what my plan coverage is. I also understand that I am responsible for all charges not covered by my insurance company that I request or that are recommended to me by my doctor.

Name_____

Signature_____

Date_____

Amber Wellness Group is not liable for unexpected fees I may incur during my treatment in the clinic.