Amber Wellness Group, LLC

1944 NE 45th Ave; Portland, OR 97213
Phone: 971.319.0045 Fax: 833.962.2422

Insurance Verification Worksheet

We want you to feel empowered and understand your insurance benefits and avoid surprises as we work together towards your optimal health.

Full payment of the patient portion 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_____

Representative's Name_____ Date Called_____

Call the member services phone number on your insurance card and ask for a customer service representative (*automated services do not provide complete information)

1. Have your ID # and Group # available (these are on the front of your insurance card).

2. Do I have benefits to see a Naturopathic doctor for an office visit?
   Yes/ No
   What is my copay/coinsurance for a Naturopathic office visit? _____
   Do I have a limited number of office visits with a Naturopathic doctor?
   Yes/ No
   If yes, how many visits? _____

3. Is my provider in or out of network?
   a. Dr. Lisa Dickinson: In / Out of network
   b. Dr. Meghan Bennett: In / Out of network
   c. Dr. Jade Wienbar: In / Out of network
   d. Dr. Sumner Van Brunt: In / Out of network

4. Does my insurance cover the following codes to cover extended time?
   G2212 Yes/ No
   99417 Yes/ No

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5. Does my plan support telemedicine visits? Yes / No

6. Is my provider able to do my Annual Exam (CPT code 99385 or 99395)?
   Yes/ No
   Am I currently eligible for my annual exam?
   Yes/ No

7. If fertility is one of my concerns, do I have fertility benefits?
   Yes/ No

8. What is my responsibility for in-network lab and imaging tests?
   _____

9. Is there a preferred local lab for blood work?
   Yes/ No (please circle)
   Quest Labcorp Other_____

10. Is there a preferred facility for imaging?
    Yes/ No (please circle)
    Legacy Providence Rayus Other_____

I understand that it is my sole responsibility to call my insurance company and find out what my plan coverage is prior to my first visit and every year when I receive my new insurance card.
I also understand that I am responsible, and Amber Wellness Group is not liable for unexpected fees I may incur during my treatment in the clinic that are not covered by my insurance company.
I will talk with my doctor to understand how the recommended diagnostic and treatment options will help us better understand my condition so that I may reach my health care goals.

Patient Name_____

Signature_____ Date_____