NOVO HEALTHNET LIMITED

DIRECT BILLING ENROLLMENT FORM

LAST NAME: _____ FIRST NAME: _____ INITIAL: _____

DATE OF BIRTH: _____ PARENT/GUARDIAN: _____
DAY / MONTH / YEAR IF APPLICABLE

PRIMARY INSURANCE BENEFITS

PLEASE CHECK OFF THE INSURANCE COMPANY

◯ CHAMBERS OF COMMERCE ◯ COWAN ◯ DESJARDINS ◯ GREAT WEST LIFE

◯ INDUSTRIAL ALLIANCE ◯ JOHNSON INC. ◯ MANULIFE ◯ SUN LIFE

◯ GREEN SHIELD ◯ STANDARD LIFE ◯ MAXIMUM BENEFIT

◯ OTHER _____

POLICY/ CLAIM #: _____ ID/CERTIFICATE: _____

NAME OF POLICY HOLDER: _____ DOB: _____
DAY / MONTH / YEAR

EMPLOYER: _____
IF DIFFERENT THAN ABOVE

SECONDARY INSURANCE BENEFITS: PLEASE NOTE WE ARE CURRENTLY UNABLE TO BILL SECONDARY COVERAGE DIRECTLY

PLEASE CHECK OFF THE INSURANCE COMPANY

◯ CHAMBERS OF COMMERCE ◯ COWAN ◯ DESJARDINS ◯ GREAT WEST LIFE

◯ INDUSTRIAL ALLIANCE ◯ JOHNSON INC. ◯ MANULIFE ◯ SUN LIFE

◯ GREEN SHIELD ◯ STANDARD LIFE ◯ MAXIMUM BENEFIT

◯ OTHER _____

POLICY/ CLAIM #: _____ ID/CERTIFICATE: _____

NAME OF POLICY HOLDER: _____ DOB: _____
DAY / MONTH / YEAR

EMPLOYER: _____
IF DIFFERENT THAN ABOVE

NOVO HEALTHNET LIMITED

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I hereby give permission to Novo Healthnet Limited to direct bill my insurance company. I am aware that the payment will be sent directly to Novo Healthnet. I am also aware that if any services are not covered by the insurance company or if any payment is not received from the insurance company my account is my financial responsibility. I also understand that it is my responsibility to understand the parameters of my plan, whether a Physician referral is required, what percentage is covered & the annual limit.

I hereby agree to have the balance applied to my credit card. I understand my credit card will only be billed for unpaid amounts following 60 days of treatment. An itemized receipt will be emailed, if provided, or mailed to my address on file.

_____

SIGNATURE **DATE**

CREDIT CARD INFORMATION

NAME ON CARD: _____ ◯ VISA ◯ MC ◯ AMEX

CARD NUMBER: _____ EXPIRY: _____ SECURITY CODE: _____
MM/YY

CARD HOLDER SIGNATURE: _____

NOVO HEALTHNET LIMITED

NOTIFICATION FOR EXTENDED HEALTH COVERAGE

PHYSIOTHERAPY COVERAGE	CHIROPRACTIC COVERAGE
Maximum Coverage Per Calendar Year: _____ Maximum Cost Per Treatment: _____ Amount Remaining: _____ MD Referral Require: _____ Coverage Checked By: _____ Date: _____	Maximum Coverage Per Calendar Year: _____ Maximum Cost Per Treatment: _____ Amount Remaining: _____ MD Referral Require: _____ Coverage Checked By: _____ Date: _____
MASSAGE COVERAGE	**COMPRESSION SOCKS COVERAGE**
Maximum Coverage Per Calendar Year: _____ Maximum Cost Per Treatment: _____ Amount Remaining: _____ MD Referral Require: _____ Coverage Checked By: _____ Date: _____	Maximum Coverage Per Calendar Year: _____ Maximum Cost Per Treatment: _____ Amount Remaining: _____ MD Referral Require: _____ Coverage Checked By: _____ Date: _____
ACUPUNCTURE COVERAGE	**CUSTOM BRACING COVERAGE**
Maximum Coverage Per Calendar Year: _____ Maximum Cost Per Treatment: _____ Amount Remaining: _____ MD Referral Require: _____ Coverage Checked By: _____ Date: _____	Maximum Coverage Per Calendar Year: _____ Maximum Cost Per Treatment: _____ Amount Remaining: _____ MD Referral Require: _____ Coverage Checked By: _____ Date: _____
APPLIANCE(S) COVERAGE	**ORTHOTICS COVERAGE**
Maximum Coverage Per Calendar Year: _____ Maximum Cost Per Treatment: _____ Amount Remaining: _____ MD Referral Require: _____ Coverage Checked By: _____ Date: _____	Maximum coverage per calendar year: _____ Maximum cost per Pair: _____ Amount Remaining: _____ MD Referral Require: _____ Who can dispense (DC or PT): _____ Who can prescribe: _____ Coverage Checked By: _____ Date: _____
OTHER COVERAGE	**OTHER COVERAGE**
Type of Service/Product: _____ Maximum Coverage Per Calendar Year: _____ Maximum Cost Per Treatment: _____ Amount Remaining: _____ MD Referral Require: _____ Coverage Checked By: _____ Date: _____	Type of Service/Product: _____ Maximum Coverage Per Calendar Year: _____ Maximum Cost Per Treatment: _____ Amount Remaining: _____ MD Referral Require: _____ Coverage Checked By: _____ Date: _____

Able to bill online: YES NO

Assignment payable to clinic: YES NO

NOVO HEALTHNET LIMITED

REFUSAL TO DISCLOSE INSURANCE INFORMATION

Refusal to Disclose Insurance Information

I, _____, do not wish to disclose my extended health care benefits insurance information to Novo Healthnet Limited.

I am aware that the reason for this request is to keep track of my coverage and agree that I will personally keep track and be responsible for my account.

_____	_____
(Patient Signature)	(Administrator Signature)
_____	_____
(Date)	(Date)