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Patient Name:	Appointment Date:	Today's Date:
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Please bring this completed form with you to your appointment

We are pleased you have chosen West Lake Family Practice and look forward to providing consistent high quality medical care and related services to you. To avoid confusion about your insurance coverage we ask that you contact your insurance company prior to your appointment to understand your specific plan benefits and coverage. Please be aware that we will bill you privately for any charges not covered by your plan, so time taken now on your part will eliminate unexpected expenses to you later. If you are unable to complete this form before your appointment, please arrive 30 minutes early to allow for completion.

This form is to be used as a guide when calling your insurance company regarding your benefits.

To find out if WLFP is a participating provider on your plan, give the insurance representative our Tax ID # 74-2888700

Name of Insurance Company	Insurance Phone number for benefits	Insurance representative spoke with:
Insurance policy holder's name:	Policy holder's Social Security #:	Policy holder's employer's name:
Policy holder's date of birth: ____ - ____ - 19 ____	_____ - _____ - _____	Policy Effective Date: _____ - _____ - _____

- 1). What type of plan do I have?** HMO PPO POS Indemnity HSA (If HSA, is there a debit card? YES NO)
 If it is an **HMO, who is the PCP?** : _____ (If the PCP is not a WLFP doctor, ask to change PCP's)
 (Have you requested a change to a WLFP doctor? Yes No)
 If HMO: Does my plan require a referral from my PCP to see a specialist or for any x-ray services? _____
- 2). Do I have coverage for laboratory testing?** YES NO
 If so, how is it covered? with a \$_____ Copay 100% 90% 80% or _____
 Do I have to meet a deductible for labs? Yes No If Yes, deductible amount? _____ How much has been met? _____

Is Clinical Pathology Labs an IN-NETWORK Lab? YES NO...if not what lab(s) are in-network _____
- 3). Do I have coverage for physicals or well visits?** YES NO
 If so, how is it covered? with a \$_____ Copay 100% 90% 80% or _____
 Do I have a deductible for physicals or well visits? Yes No If Yes, deductible amount? _____ How much has been met? _____
- 4). Do I have coverage for a problem visit?** YES NO
 If so, how is it covered? with a \$_____ Copay 100% 90% 80% or _____
 Do I have a deductible for problem visits? Yes No If Yes, deductible amount? _____ How much has been met? _____
- 5). Do I have coverage for procedures?** YES NO
 If so, how is it covered? with a \$_____ Copay 100% 90% 80% or _____
 Do I have to meet a deductible for procedures? Yes No If Yes, deductible amount? _____ How much has been met? _____
- 6). Do I have any preexisting conditions not covered?** YES NO What? _____
- 7). (Women, if relevant to you) Do I have coverage for Oral Contraception?** YES NO **Depo Provera?** YES NO

If at any time, while you are a patient at **West Lake Family Practice**, you change your PCP, insurance plan, or are informed of benefits changes, please inform our business office as soon as possible. Any claims that must be refilled due to lack of current or correct insurance information at the time of service may be subject to a \$25 refiling fee prior to refiling.

-THANK YOU -