

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

- | | | | |
|--|-------------------------------------|---------------------------------------|---------------------------------------|
| <input type="radio"/> CHAMBERS OF COMMERCE | <input type="radio"/> COWAN | <input type="radio"/> DESJARDINS | <input type="radio"/> GREAT WEST LIFE |
| <input type="radio"/> INDUSTRIAL ALLIANCE | <input type="radio"/> JOHNSON INC. | <input type="radio"/> MANULIFE | <input type="radio"/> SUN LIFE |
| <input type="radio"/> GREEN SHIELD | <input type="radio"/> STANDARD LIFE | <input type="radio"/> MAXIMUM BENEFIT | |
| <input type="radio"/> 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

- | | | | |
|--|-------------------------------------|---------------------------------------|---------------------------------------|
| <input type="radio"/> CHAMBERS OF COMMERCE | <input type="radio"/> COWAN | <input type="radio"/> DESJARDINS | <input type="radio"/> GREAT WEST LIFE |
| <input type="radio"/> INDUSTRIAL ALLIANCE | <input type="radio"/> JOHNSON INC. | <input type="radio"/> MANULIFE | <input type="radio"/> SUN LIFE |
| <input type="radio"/> GREEN SHIELD | <input type="radio"/> STANDARD LIFE | <input type="radio"/> MAXIMUM BENEFIT | |
| <input type="radio"/> OTHER _____ | | | |

POLICY/ CLAIM #: _____ ID/CERTIFICATE: _____

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

EMPLOYER: _____
IF DIFFERENT THAN ABOVE

NOVO HEALTHNET LIMITED

DIRECT BILLING ENROLLMENT FORM

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

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

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)