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

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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

Maximum coverage per calendar year: _____
Maximum cost per treatment: _____
Amount Remaining: _____
MD Referral Require: _____

MASSAGE COVERAGE

Maximum coverage per calendar year: _____
Maximum cost per treatment: _____
Amount Remaining: _____
MD Referral Require: _____

CHIROPRACTIC COVERAGE

Maximum coverage per calendar year: _____
Maximum cost per treatment: _____
Amount Remaining: _____
MD Referral Require: _____

ORTHOTICS COVERAGE

Maximum coverage per calendar year: _____
Maximum cost per treatment: _____
Amount Remaining: _____
MD Referral Require: _____
Who can dispense (DC or PT): _____
Who can prescribe: _____

NATUROPATHIC/DIETICIAN COVERAGE

Maximum coverage per calendar year: _____
Maximum cost per treatment: _____
Amount Remaining: _____
MD Referral Require: _____

ACUPUNCTURE COVERAGE

Maximum coverage per calendar year: _____
Maximum cost per treatment: _____
Amount Remaining: _____
MD Referral Require: _____