Dyker Heights Family Chiropractor
Assignment of Benefits Agreement

Patient Name_____ Date of Birth_____

Patient Address_____ City/State/Zip_____

Insurance Carrier:_____ Plan Name:_____

Member ID#:_____

I hereby certify that the insurance information that I have provided Dyker Heights Family Chiropractor is true and accurate as of the date of service. I certify that benefits, to pay any and all medical claims, are available as of the date of this agreement. If authorization is needed to provide me with medical care, I certify that I have obtained said authorization, or have instructed Dyker Heights Family Chiropractor to obtain authorization from my insurance company, in order to seek medical care from Dyker Heights Family Chiropractor.

I understand that intentionally providing false insurance information may be considered as fraud. I am fully aware that having health insurance does not release me of my responsibility to ensure that my medical bill is paid in full. I also understand that my insurance company may not pay 100% of the amount of the medical claim and I may be responsible for any and all amounts not payable by my insurance company.

I hereby authorize Dyker Heights Family Chiropractor to submit claims, on my behalf, to the insurance company listed on the copy of the current insurance card I have provided, in good faith. I fully agree and understand that the submission of a claim does not release me of my responsibility to ensure that the claim is paid in full.

I hereby instruct and direct_____ Insurance Company, to pay by check, made payable to and mailed to:
Dyker Heights Family Chiropractor
7301 New Utrecht Avenue
Brooklyn NY 11204.

If my current policy prohibits direct payment to the provider of service, I hereby also instruct and direct _____ Insurance Company to make the check payable to me and mail it to:
Dyker Heights Family Chiropractor
7301 New Utrecht Avenue
Brooklyn NY 11204
where I will endorse the check and surrender payment for the professional or medical expense benefits allowable.

This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. Upon receipt of said check, I authorize Dyker Heights Family Chiropractor to deposit checks received on my account when made out to me. I authorize Dyker Heights Family Chiropractor to make deposit into the account of Dr. Baudille on my behalf. I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. A photocopy of this document shall be considered as effective and valid as the original.

_____ _____

Signature of Patient Doctor Signature

_____ _____

Signature of Policyholder (if not patient) Date

_____

Date

DYKER HEIGHTS FAMILY CHIRORACTOR: Designation of Authorized Personal Representative

I authorize Dyker Heights Family Chiropractor to be my personal representative, which allows Dyker Heights Family Chiropractor to: (1) submit any and all requests for benefit information from my insurance company and to receive such information on my behalf, (2) submit any and all appeals when my insurance company denies me benefits to which I am entitled, and (3) initiate formal complaints to any State or Federal agency that has jurisdiction over my policy/benefits. I fully understand and agree that I am responsible for full payment of my accrued medical debt if my insurance company has refused to pay 100% of my benefits, within ninety (90) days of any and all appeals or requests for information. I also agree that any fines levied against my insurance company will be paid to Dyker Heights Family Chiropractor for acting as my personal representative.

A photocopy of this document shall be considered as effective and valid as the original.

_____

Printed Patient Name

_____

Signature of Patient

_____

Signature of Policyholder (if not patient)

_____

Date

_____

Doctor Signature

_____

Date

_____

Witness signature

_____

Date