

MORaine VALLEY CHIROPRACTIC CENTER

INSURANCE INFORMATION

RESPONSIBLE PARTY/INSURANCE INFORMATION

Name of person responsible for account
BirthDate
Insurance Company or Health Care Plan Name
Policy/Group #:
Name of Insured:
Relationship To Patient: Self Spouse Child Other

YOUR EMPLOYER Company Name
Address
City
Occupation
Full-time Part-time

SPOUSE (PARENT) Name
BirthDate
Employer Name
Address
City
Social Security #
Occupation
Phone
State Zipcode

DO YOU HAVE ADDITIONAL INSURANCE? Yes/No If yes, complete the following:
Insurance Company or Health Care Plan Name
Policy/Group #:
Name of Insured:

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Moraine Valley Chiropractic Center all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I acknowledge that all the above statements are true. I have read and fully understand this agreement.

Signature of Insured / Guardian Date