

DUNNE CHIROPRACTIC CENTER

315 WEST 63RD STREET

WESTMONT, IL 60559

PHONE: (630) 968-6969

FAX: (630) 968-8938

ASSIGNMENT OF BENEFITS FORM

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier{s}, including Medicare, private insurance, auto or any health/medical plan, to issue payment check(s) directly to Dunne Chiropractic, for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Dunne Chiropractic, to (1) release any information necessary to insurance carriers regarding my treatments and condition; (2) process insurance claims generated in the course of examination of treatment; (3) allow a photocopy of my signature to be used to process insurance claims for the period lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Dunne Chiropractic on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges not covered by insurance if any incurred in the course of the treatment.

I further understand that fees are due and payable on the date that the services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid to the original.

Patient/Responsible Party Signature

Date