



Assignment of Benefits

Doctor _____

Insurance name/Nombre de aseguranza: _____

ID#/Número de ID: _____ **Group#**/Número de grupo: _____ **Policy#**/Número de póliza: _____

Address/Dirección: _____

Adjuster/Ajustador: _____ **Phone**/Telefono: _____

You are instructed to pay directly to Shoar Chiropractic, Inc. for all professional services to me by this office.

This instruction to you is an assignment of my rights under medical coverage to the event of this bill.

Any sum of money paid under this assignment shall be credited to my account and I shall be personally liable for any unpaid balance to the doctor. Also, I am personally liable for any unpaid accounts for diagnostic or consultant services.

Name/Nombre: _____ **Signature**/Firma _____

Address/ Dirección: _____

Se le dan instrucciones para pagar directamente al Shoar Chiropractic, Inc. para todos los servicios profesionales que me ofrece esta oficina.

Esta instrucción para usted es una cesión de mis derechos bajo la cobertura médica para el caso de este proyecto de ley.

Cualquier suma de dinero que se paga en virtud de esta asignación se abonará en mi cuenta y voy a ser personalmente responsable de cualquier saldo no pagado al médico. Además, yo soy personalmente responsable de cualquier hospital de cuentas pendientes de pago, de diagnóstico y servicios de consultoría.

Acknowledgement of Insurance Company

This insurance company hereby acknowledge receipt of the above instruction and agrees to mail payment of medical coverage benefits of the policy directly to the office of **Shoar Chiropractic, Inc.**

Authorized Signature: _____ Date: _____

Note: In the event this acknowledgment is not signed and returned to the office of the doctor within seven (7) days, it will be assumed and relied upon that the insurance company has agreed to and acknowledges medical coverage and payment directly to **Shoar Chiropractic, Inc.**