ASSIGNMENT OF BENEFITS FORM

PATIENT'S NAME: ____

NAME OF INSURED: ____

INSURANCE I.D. NUMBER: ____

I hereby assign all medical benefits to which I am entitled to Cynergy Chiropractic Center, Inc. This applies for all insurance carriers, including Medicare, private insurance, and any other health/ medical plan. This form will be kept on file.

I understand that it is my responsibility to report any changes in insurance coverage to Cynergy Chiropractic Center, Inc.

I authorize the release of any medical or pertinent information necessary to obtain these benefits to my insurance carrier, or any other medical entity for continued medical care.

I understand that I am financially responsible for any amount not covered by insurance.

____
Signature of Patient or Personal Representative

____
Printed Name of Patient or Personal Representative

____
Date

____
Description of Personal Representative's Authority

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