Broadway Chiropractic Office

72 W Broadway
Derry, NH 03038

Date: _____

Patients Name: _____ Chief Complaint: _____

Date of Birth: _____ Phone Number: _____

Insurance Company: _____ ID#:_____

Ins. Phone: _____ Name of the Insured: _____

Are your present symptoms or conditions related to or the result of an auto collision, work-related injury or other personal injury someone else might be responsible for? ___ Yes ___ No

Family Physician: _____ Name of Facility: _____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

_____ Personal Injury Patients Initial Here to indicate you understand that checks may be drawn directly to you from the insurer, and any such funds made payable to you for services rendered at this facility are immediately due and payable to Broadway Chiropractic Office, PLLC.

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 Broadway Chiropractic Office, PLLC 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 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.

I understand that there will be no fees charged if I give 24 hours notice to cancel or reschedule an appointment.

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 have read and fully understand this agreement.

_____ _____

Signature of Insured / Guardian Date