ASSIGNMENT OF BENFITS/ERISA AUTHORIZATION FORM

Financial Responsibility

I have requested professional services from Infinity Chiropractic & Wellness on behalf of myself and/or my dependents, and understand that by making the request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Provider. I certify that the health insurance information that I provided to Provider to accurate as the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Provider to submit claims, on my and/or my dependent's behalf to the benefit plan (or its administrator) listed on the current insurance card I provided to Provider in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependants. To the extent that my current policy prohibits direct payment to Provider. I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the checks to me and mail it directly to Provider.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance and deductibles.

Authorization to Release Information

I hereby authorize Provider to: (1) release any information necessary to my health benefit plan(or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan (1) the right and ability to act on my behalf in connection with any claim, right or cause in action that I may have under such insurance policy and/or benefit plan; and (2)the right and ability to act on my behalf to pursue such claim, right or cause of action in connection and said insurance policy and/or benefit plan (including but not limited to the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. 2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and to the extent permissible under the law to claim on my behalf, such benefits, claims or reimbursement, and any other applicable remedy including fines.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

Patients Name: _____ Date: _____

Policyholder/Insured_____ Date: _____