ELIGIBILITY GUARANTEE/ASSIGNMENT OF BENEFITS FORM

I, _____, hereby certify that I am eligible for chiropractic benefits
(Name of Patient/Member/Guardian)

offered by _____ as of _____.
(Name of Health Plan) (Today's Date)

I understand that if the above is not true, or if I am not eligible under the terms of my Insurance Policy, I am liable for all charges for services rendered. Also, if the above is not true, I agree to pay in full for all services received within thirty (30) days of receiving a bill from the above Chiropractor or Health Plan.

Assignment of Benefits:

I authorize the release of any health information necessary to process this claim. A photocopy of this authorization shall be effective and valid as the original.

I authorize payment of medical benefits to the Chiropractor listed above who accepts assignment through his/her contract with above listed health plan.

I understand that the Chiropractor will not bill me for any charges over and above the insurance payment, other than the applicable co-payments, co-insurance or deductible, since the Chiropractor has agreed in his/her contract the above listed Insurance Company to waive all unpaid fees.

_____ _____
(Date) (Signature of Member or Subscriber)