D'Agostino Chiropractic & Associates, P.C.

96 Manner Avenue
Garfield, NJ 07026
Phone/Fax (973) 772-0099

ASSIGNMENT, LIEN, AUTHORIZATION OF INSURANCE BENEFITS AND POWER OF ATTORNEY

Name of Patient:
Date of Accident:

I hereby authorize and direct any insurance company and/or my attorney to pay directly to D'Agostino Chiropractic, P.C. such sums as may be due and owing this office for services rendered to me, both by reason of accident or illness and by reason of any other bills that are due this office, and to withhold such sums from any disability benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said Office.

I hereby assign all of my interest and rights to all insurance benefits, which shall include, but not be limited to the right to file a lawsuit or seek arbitration for benefits relative to treatment by said Office. I hereby assign and transfer to this Office any and all causes of action that I might have or that might exist in my favor against any insurance carrier that may be liable for payment of benefits, and authorize this Office to compromise, settle or otherwise resolve said claim or cause of action as they see fit. Further, in the event that the within assignment is not consented to by an insurer or in any other manner is held invalid by any party, judge, arbitrator or any other person, I hereby give this Office the power of attorney to bring any arbitration proceeding or suit in my name on my behalf as if I had filed such action myself. I further agree to fully cooperate with regard to prosecuting such action or proceeding.

I understand that I remain personally responsible for the total amount due the Office for services, subject to New Jersey Law. I further understand and agree that this Assignment, Lien and Authorization does not constitute any consideration for the Office to await payments and they may demand payments from me immediately upon rendering services at their option.

I authorize this office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment, Lien and Authorization, so long as the request is submitted in writing. I agree that the above-mentioned Office is hereby given Power of Attorney to endorse/sign my name on any and all checks for payment of my doctor's bill. I further authorize any insurance company and any other physicians who have treated me for this accident or illness to provide this Office with any documentation needed with regard to the payment of my bills.

Date:____________________ Patient's Signature________________________________

Witness: ________________________________

Assignment of Benefits Form

D'Agostino Chiropractic
96 Manner Avenue
Garfield, NJ 07026
(973)772-0099

Date:_________

Patient:____
Employer:____
Claim Group:____
SS#/ID#:____

I hereby instruct and direct ___________________ Insurance Company to pay by check, made out, and mailed to:

D'Agostino Chiropractic
96 Manner Avenue
Garfield, NJ 07026

If my current policy prohibits direct payment to Dr. D'Agostino, I herby also instruct and direct you to make out the check to me and mail it as follows:

D'Agostino Chiropractic
96 Manner Avenue
Garfield, NJ 07026

For the professional or medical expense allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY**. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

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

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated at *D'Agostino Chiropractic* this__________day of______________, 20___

____
Signature of Policyholder

____
Witness

____
Signature of Claimant, if other that policyholder.