POSTURE PERFECT CHIROPRACTIC, P.C.

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(973) 324-9324 / Fax (973) 324-9339
Dr. Carmine Allonardo

ASSIGNMENT OF BENEFITS FORM

PATIENT NAME:_____

I IRREVOCABLY ASSIGN TO DR. CARMINE ALLONARDO ALL MY RIGHTS AND BENEFITS UNDER ANY INSURANCE CONTRACTS FOR PAYMENT FOR SERVICES RENDERED TO ME BY POSTURE PERFECT CHIROPRACTIC. I IRREVOCABLY AUTHORIZE DR. CARMINE ALLONARDO TO PURSUE ANY, AND ALL CLAIMS ARISING FROM MY CASE. I IRREVOCABLY AUTHORIZE DR. CARMINE ALLONARDO ALL INFORMATION REGARDING MY BENEFITS UNDER ANY INSURANCE POLICY RELATING TO ANY CLAIMS BY DR. CARMINE ALLONARDO TO BE RELEASED TO POSTURE PERFECT CHIROPRACTIC. I IRREVOCABLY AUTHORIZE DR. CARMINE ALLONARDO TO FILE INSURANCE CLAIMS ON MY BEHALF FOR SERVICES RENDERED TO ME. I IRREVOCABLY AUTHORIZE POSTURE PERFECT CHIROPRACTIC TO ACT IN MY BEHALF AND REPORT ANY SUSPECTED VIOLATIONS OF PROPER CLAIMS PRACTICES TO THE PROPER REGULATORY AUTHORITIES.
THIS ASSIGNMENT OF BENEFITS HAS BEEN EXPLAINED TO MY FULL SATISFACTION AND I UNDERSTAND ITS NATURE AND EFFECT.

PATIENT SIGNATURE:_____

DATE:_____