Assignment of Benefits

I, the undersigned, irrevocably assign to the below named healthcare professionals, my care providers, all the rights and benefits under my insurance contract for payments and services rendered to me.

I irrevocably authorize all information regarding by benefits under my insurance policy relating to any claims by the below named healthcare professionals to be released to the same.

I irrevocably authorize the below named health care professionals to file insurance claims on my behalf for services rendered to me in the course of care, and this specifically includes filing arbitration/litigation in my name on my behalf against the health care carrier/PIP carrier. I irrevocably direct that all such payments go directly to Chiropractor On Wheels, LLC.

I irrevocably authorize the below named health care professionals to act on my behalf. I consent to their acting on my behalf in this regard and in regard to my general health insurance coverage pursuant to the benefit denial process set forth in the NJ Administrative Code and report any suspected violations of proper claims practices to the proper regulatory authorities.

In the event the insurance carrier responsible for making medical payments in this matter does not accept my assignment, or any assignment is deemed invalid, I execute this limited power of attorney and appoint your collection attorney as my agent to collect payment for your medical services directly against the carrier in this case including filing an arbitration demand or lawsuit. I specifically authorize that attorney to file directly against that carrier in my name or in your name as a medical provider rendering services to me.

This assignment of benefits has been explained to my full satisfaction and I understand its nature and effect.

Initial: _____

Any services that are not covered by your insurance is your responsibility and will be due and payable upon receipt of a billing statement. If correct insurance information or referral is not presented at the time of service, you are responsible for the full amount of the charges incurred. If you do not have medical insurance, financial arrangements may be made.

If you understand and accept the foregoing, please sign on the line provided below:

Signed: _____ Date: _____

Print Name: _____

Name of Minor Child (if applicable): _____

Chiropractor On Wheels, LLC
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Robert Press, MS, DC
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