SeaCoast
FAMILY CHIROPRACTIC

Assignment of Benefits Form

Name of insured: _____

Insurance I.D. Number: _____

I hereby assign all medical benefits to which I am entitled to Sea Coast Family Chiropractic. This applies for all insurance carriers, including Medicare, private insurance, and any other health/medical plan. This form will be kept on file.

I understand that it is my responsibility to report any changed in insurance coverage.

I authorize Sea Coast Family Chiropractic to submit claims to my insurance company on my behalf and I authorize the release of any medical or pertinent information necessary to obtain these benefits to my insurance carrier, or any other medical entity for continued medical care.

I understand that I am financially responsible for any amount not covered by insurance.

Signature: _____ Date: _____ /_____ /_____