

Matlock Road Chiropractic Center
Frank R. Greenberg, D.C., P.C.

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**Assignment of Benefits-Policy of Payment
Authorization and Release of Information
Consent to Treat**

Assignment of Benefit: I hereby assign all medical benefits, to include Major Medical benefits to which I am entitled, including Medicare, private insurance, auto (PIP/Med pay) and any other health plans to Matlock Road Chiropractic. **I agree that all payments are to be payable solely to and sent directly to Dr. Frank Greenberg, at the address shown above, regardless of any other agreements or contracts I may enter into with any attorney or any other individual, group or other company subsequent to this date.**

Policy of Payment: We will file your claim forms and assist you in every way we can. However, the contract is between you and your insurance company and you are fully responsible for any account not paid by your insurance plan. Our office does **NOT** guarantee that your insurance will pay. We will make every attempt, at the beginning of your health care, to receive verification of your policy and what it covers. However, if for some reason, your claim is denied or your policy changes, and changes affect the verification received from your insurance company, you will be responsible for the full amount of your bill. Our office will **NOT** enter into dispute with your insurance company over your claim. This is your responsibility and obligation.

Authorization: I authorize the release of all information necessary, including medical information, to secure payment for services rendered, including the processing of insurance claims, to also include the release of any information necessary to secure payment for any additional expenses that may be incurred by Matlock Road Chiropractic resulting from payment securing process (administrative/clerical expenses and/or fee, postage, telephone expenses, etc.)

Consent to Treat: I give my consent to Matlock Road Chiropractic to perform any and all examinations, test, treatment, physical therapy and other reasonable measures it deems necessary to diagnose and treat my condition.

My signature affirms all of the statements made above.

Date: _____ Signature: _____

Witness _____ Date: _____