

Chiropractic & Wellness Center, P.C.
1630 E. High Street, Medical Arts Bldg # 3
Pottstown, PA 19464
610-323-6858

ASSIGNMENT OF BENEFITS

To my insurance carrier(s): _____

1. I authorize the release of any medical information necessary to process my insurance claims(s) to Chiropractic & Wellness Center, P.C.
2. I authorize and request payment of medical benefits directly to Dr. Niraj Patel.
3. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me.
4. I agree that a photocopy of this form may be used in lieu of the original.
5. I agree to pay all charges not covered by my insurance carrier(s). These charges include but are not limited to deductibles and co-payments of my insurance policy.

Signature

Date