

**Hoffman Family Chiropractic Center
908 Richmond Avenue
Pt. Pleasant Bch., NJ 08742
(732) 295-1211
Fax:(732) 295-7911**

**OUR OFFICE POLICY
REGARDING INSURANCE ASSIGNMENT**

Our office is pleased to accept your insurance assignment, as soon as your exact coverage is verified by the responsible party. We will file your claim forms and assist you in every way we can.

However, it must be fully understood that the contract is between you and your insurance company and you are fully responsible for any amount not paid by your insurance.

Office policy regarding insurance assignment:

1. Since by taking your insurance on assignment, we have to wait for payment, this courtesy may be withdrawn if circumstances warrant it.
2. If you discontinue care without the doctor's authorization, the balance of your account is due and payable in full immediately, even if your insurance has been filed. (If the insurance does pay, it will be refunded if you have a zero balance.)
3. Your insurance should pay within 30 days. If your insurance has not paid within 60 days, you must pay the balance due and be reimbursed by your insurance company when and if it pays.
4. You may pay the percentage of your responsibility as you go along, if you choose. (e.g. If your insurance pays 80% of your care, you may pay 20% on each office visit)
5. Or we will bill your insurance company weekly, and when we receive an insurance we will bill you for any balance due at that time.
6. You are required to sign an "Authorized to Pay Physician" form and any other assignment documents required by your insurance company on your first office visit.
7. 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 insurance claim is denied, you are responsible for the full amount of your bill.
8. Our office will NOT enter a dispute with your insurance company over your claim. This is your responsibility and obligation.
9. If you understand and agree with all of the above office policies, please sign your name below and we will accept your insurance assignment.
10. If at any time my balance reaches above \$100, I give my authorization to have the said amount billed directly to my credit card account # _____.
Expiration date _____.

X _____

Date: _____

ASSIGNMENT OF BENEFITS AND POWER OF ATTORNEY TO CASH CHECKS

I, the undersigned, do hereby authorize payment directly to the office above, the benefits of my coverage, if any, otherwise payable to me for services but not to exceed the customary charge for those services. If these payments are made out to me I grant unto the office below as attorney the full power and authority in my name and stead to endorse any and all checks and drafts or money orders. I hereby authorize the doctor to release all information necessary to secure payment of benefits. A photocopy of this assignment shall be valid.