



CHIRO REHAB CENTER

220 Hamburg Turnpike Suite 14A • Wayne, NJ 07470 | T:(862) 336-1600 • F:(862) 336-1601

Assignment of Benefits

Patient Name:	_____
Insurance Company:	_____
Policy, Group #:	_____
SS# / ID# / Claim #:	_____

I hereby authorize the _____ Insurance Company to pay by check made out and mailed to:

AKM Chiro-Rehab Center, LLC
220 Hamburg Turnpike, Suite 14A
Wayne, NJ 07470

for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said Professional Service charges over and above this insurance payment,

If my current policy prohibits direct payment to AKM Chiro-Rehab Center, I hereby also authorize you to make the check to me and mail it as follows:

AKM Chiro-Rehab Center, LLC
220 Hamburg Turnpike, Suite 14A
Wayne, NJ 07470

I also hereby assign to AKM Chiro-Rehab Center, LLC all of my rights to obtain payment under the personal injury protection provisions of an automobile insurance policy or any other health insurance policy of any medical bills incurred as a result of my treatment, including the option to submit any dispute in my name to binding arbitration under the auspices of the American Arbitration Association or any other form that the provider deems appropriate.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

A photocopy of this Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in case.

(Signature of Policyholder)

(Date)

(Signature of Claimant, if other than Policyholder)