# ASSIGNMENT OF INSURANCE BENEFITS

**ASSIGNMENT:** I hereby assign to Houston Family Chiropractic Center all of the benefits payable under my health insurance policy/plan for the services described on the claim form submitted to my insurer herewith, and ***I AUTHORIZE, INSTRUCT AND DIRECT SAID INSURER TO PAY SUCH BENEFITS DIRECTLY TO HOUSTON FAMILY CHIROPRACTIC CENTER.***

This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge that this assignment is legally binding on me and on my insurer and will allow the Clinic to collect my insurance benefits as payment of claims for services. If for any reason, however, my insurance company pays such benefits to me instead of directly to the Clinic, I agree to immediately turn over such payments to the Clinic.

A photocopy of this assignment shall be considered as effective and valid as the original.

**RELEASE OF INFORMATION AUTHORIZED: I authorize my insurance carrier to release information regarding my coverage to Houston Family Chiropractic Center (the "Clinic"). I also authorize the Clinic to release any of my medical information and/or reports related to my treatment to my insurance carrier as needed to process a claim for benefits or to obtain insurance proceeds.**

**FINANCIAL RESPONSIBILITY OF PATIENT** I agree to be financially responsible for all charges incurred at this Clinic, including my insurance deductible, copayment, and any services for which coverage or payment is denied for any reason by my insurer. I further agree and acknowledge that I will remain financially responsible for all charges incurred at this Clinic that are covered by my insurance until such time as the Clinic actually receives payment from my insurer (or from me, if my insurer for any reason fails to pay the Clinic directly) for all services provided by the Clinic.

DATE: ____________________

____________________________________
PATIENT SIGNATURE

**TO INSURER:**

**This Assignment of Benefits executed by ______________________________ (Patient), is submitted with the claim for benefits attached hereto and requires you under Texas Insurance Code §1204.054 to pay said benefits directly to the Houston Family Chiropractic Center, 1445 North Loop west, Ste. 120, Houston, TX 77008 / Tel: (713) 864-9355.**

**Please indicate your receipt and acknowledgment of this Assignment of Benefits by signing below and faxing back to us at (713) 864-7211. (Failure to execute or return this receipt and acknowledgment shall not relieve Insurer of its obligation to pay benefits in conformance with this Assignment.)**

**Received and Acknowledged:**

**Date:** ____________________

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**Insurer's Receiving Representative**