NASHUA FAMILY CHIROPRACTIC

Brandon Linatsas, DC
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ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYYMENT TO DOCTOR

Private, Group, Accident, HMO, PPO and Health Insurance

Patient Name:	
Insurance Information	
Subscriber/Policyholder Name:	Policy Holder D.O.B. (mm/dd/yyyy) / /
Subscriber/Policyholder Employer:	
Subscriber/Policyholder Address:	
Relationship to Patient (If not Patient):	
Insurance Company:	
Policy/Group #:	
ID Number:	
Is the patient covered by additional insurance? ☐Yes ☐No	
If Yes, Subscriber's Name:	
Subscriber's Address:	
Relationship to Patient:	
Insurance Company:	
Policy/Group #:	
ID Number:	

I hereby instruct and direct that_____

insurance company pay by check made out and mailed to:

Nashua Family Chiropractic, P.C., 29 Riverside Street, Unit B, Nashua, NH 03062

If current policy prohibits direct payment to the doctor, then I hereby direct you to make the check payable to myself and Nashua Family Chiropractic P.C. and mail it to:

Nashua Family Chiropractic, P.C., 29 Riverside Street, Unit B, Nashua, NH 03062

Other side

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy is to be used as payment toward the total charges of the professional services rendered.

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

This payment will not exceed my indebtedness to the above-mentioned assignee, and **I have agreed to pay, in a prompt manner, any balance of said professional service charges over and above this insurance payment.**

A photocopy of this agreement shall be considered as a valid as the original.

I authorize the release or reception of any information pertinent to my case to/from any insurance company, the insurance adjustor, health care establishment, or attorney involved. I also authorize the doctor to complain on my behalf to the insurance commissioner if the insurance company defaults on this agreement for any reason.

I understand that by authorizing this release of my medical records I also release Nashua Family Chiropractic P.C. from all legal responsibility or liability that may arise from the release of these medical records. This authorization is valid until further notification to the contrary.

Date: _____/_____/_____ _____

Signature of Policyholder/ Patient

Date: _____/_____/_____ _____

Signature of Patient if other than Policyholder