BACK2BACK
CHIROPRACTIC

ATTENTION !!!

The "Assignment / Direct Payment to Doctor" form is an interactive form. (*Interactive means that you may type in your information.*) However, you can still print the form and fill in the requested information in pen and ink.

If you wish to utilize this interactive form by typing in the requested information, you must follow the instructions below in order to protect the privacy of your information:

1. Save the form to your computer and remember where you save it.
2. Close out your internet browser.
3. You can now open the form in Adobe Acrobat Reader and fill in all the requested information.
4. Please do not close the form before you PRINT it or all your information will be lost.

The data that you input to this form cannot be saved and a warning will appear informing you.

Thank You

Continue

Print Form

BACK2BACK CHIROPRACTIC

ASSIGNMENT / DIRECT PAYMENT TO DOCTOR

RE: _____

Patient: _____

Insurance Company: _____

Claim Number: _____

I hereby instruct and direct my insurance company to pay the following provider direct payment for services:

◯ 4124 Walney Road, Suite N
Chantilly, VA 20151
Ph: 703-378-8633
Fax: 703-378-7388

◯ 12847 Braemar Village Plaza
Bristow, VA 20136
Ph: 703-365-8333
Fax: 703-365-0448

If policy provisions prohibit direct payment to my physicians, I hereby request payment for services rendered per current policy provisions be made to me. Payment is 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 professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.**

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in current manner any balance of said professional services charges over and above this insurance payment. A photocopy of this Assignment of Rights and Benefits shall be considered as effective and valid as the original.

I understand that any money paid to me by my insurance company is for services rendered by Back 2 Back Chiropractic and will therefore be directly signed over to them or paid in full by me. I also understand that I must sign over checks or pay Back 2 Back Chiropractic in full within 2 weeks of receiving money from my insurance or I will also be responsible for all interest that would accrue on this money between the due date and the date paid at 1.5% per month plus any fees incurred in collecting the monies.

I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ Signature

_____ Date