MY Chiropractic Health and Wellness Centre

Insurance Information

Benefit Assignment Form

Provider: MY Chiropractic Health and Wellness Centre
108 Carlyle Cres., Aurora, ON L4G 6P7
905-898-6644

Patient Name: ____

Address: ____

City/Province: ____

Postal Code: ____

Phone Number: ____

Insurance Provider and Plan Number: ___________________________________

Certificate/Plan Number:____

I hereby assign benefits payable for the eligible claims to the Provider responsible for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to the Provider. In the event my claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to the Provider for any service rendered and/or supplies provided.

I acknowledge and agree that the insurer/plan administrator is under no obligation to accept this Assignment, that any benefit payment made in accordance with the Assignment will discharge the insurer/plan administrator of its obligations with respect to that benefit payment, and in the event the benefit payment is made to me, the insurer/plan administrator will also be discharged of its obligation with respect to that benefit payment.

I understand that this Assignment will apply to all eligible claims submitted electronically by the Provider and that I may revoke it at any time by providing written notice to the insurer/plan administrator.

If I am a spouse or dependent, I confirm that I am authorized by the plan member to execute an assignment of benefit payments to the Provider.

____________________________ ____

Date Signature

____

Print Name

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Most extended insurance benefit plans contribute towards Chiropractic, Orthotics /Orthopedic Shoes, Registered Massage Therapy and Naturopathic Medicine. Policies vary so please review your personal insurance coverage and let us know about your coverage and any specific details of your plan on ***your next visit***. We are working with a select number of insurance companies to provide you with direct billing.

PLEASE RETURN ON YOUR NEXT VISIT

PATIENT'S NAME: ____

NAME OF INSURED MEMBER: _____________________________________

Insured Members Date of Birth: _________________________________

EMPLOYER: ____

INSURANCE COMPANY NAME: ___________________________________

POLICY/ID ***OR*** PLAN#:__________________ MEMBER ID#:___________________

PERCENTAGE COVERAGE: 100% □ OTHER □ ________ %

FULL COVERAGE: □ DEDUCTIBLE: □ CO-PAY AMOUNT: $_______

CHIROPRACTIC $ ___________ PER YEAR

X-RAYS $ _________ PER YEAR

ORTHOTICS (Custom Made) $ ____________ PER 1 2 3 YEAR(S)

Prescription Needed NO □ YES □

From Chiropractor / M.D. / OTHER?

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