Chiropractic Health Center of Hamburg
Peter B Karas, DC, CPT
Hamburg, NJ 07419
Phone: 973-827-8150

Date _____

Patient Name: _____

Employer: _____

Insurance Co: _____

Claim Group: _____

ID # _____

I hereby instruct and direct _____**Insurance Company** to pay by check made out and mailed to:

Dr. Peter B Karas, DC 11 Vernon Ave, Hamburg New Jersey 07419

If my current policy prohibits direct payment to the doctor, I hereby also direct and instruct you to make the check payable to me but mailed to the following:

Dr. Peter B Karas, DC 11 Vernon Ave, Hamburg, New Jersey 07419

For the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment towards the total charges for professional services rendered. THIS IS A DIRECT ASSIGMENT 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 the current manner, any balance of said professional service charge over and above this insurance payment.

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

I hereby authorize any plan member of fiduciary, insurer, and my attorney to release to such doctor and clinic all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursements, or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I authorize the above-mentioned doctor to initiate a complaint to the Insurance Commissioner and ERISA for any reason on my behalf.

Dated: _____

Signature of Policyholder _____ **Witness**_____

Signature of Claimant, If other than Policyholder _____