Absolute Balance Acupuncture Clinic

25-15 Fair Lawn Avenue, Fair Lawn, NJ 07410
Phone: 201-916-0509; Fax: 201-815-2073

ASSIGNMENT OF BENEFITS

PATIENT'S NAME: ____ DATE: ______/______/________

I hereby authorize Absolute Balance Acupuncture Clinic, LLC, T. Volin, L. Ac., Dipl. OM. (NCCAOM) to apply for health insurance benefits (if applicable, no-fault and/or worker's compensation) on my behalf.

I authorize payment from all such carriers be made directly to the provider.

I certify that the information I have reported with regard to my insurance carrier(s) is correct.

I authorize the release of medical information about me to my insurance carrier(s) and HCFA (Health Care Financing Administration) agents, any and other information needed to determine the benefits payable for related service(s).

I release any holder of Medicare information about me to my insurance carrier(s) necessary to determine benefits payable for related services.

SIGNATURE OF PATIENT/GUARDIAN DATE

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Absolute Balance Acupuncture Clinic, LLC, T. Volin, L. Ac., Dipl. OM. (NCCAOM) and its associates to provide treatment and/or examination and release any information per patient to my case in the course of my examination or treatment to my physician, insurance company, adjuster, or attorney if applicable in this case.

SIGNATURE OF PATIENT/GUARDIAN DATE