FOSTER Family & Sports CHIROPRACTIC, L.L.C.

Alan K. Foster, D.C.
Chiropractic Physician
Renee T. Foster, B.S., D.C.
Chiropractic Physician

127 Union Avenue
Middlesex, NJ 08846
Telephone: (732)-537-0009
Facsimile: (732)-537-9966

ASSIGNMENT OF BENEFITS AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR

PATIENT: _____

INSURANCE COMPANY _____

CLAIM/GROUP# _____

SS/ID# _____

I irrevocably assign to **FOSTER Family & Sports CHIROPRACTIC, L.L.C.** all my rights and benefits under any insurance contracts for payment for services rendered to me by **FOSTER Family & Sports CHIROPRACTIC, L.L.C.** I irrevocably direct that all such payments go directly to **FOSTER Family & Sports CHIROPRACTIC, L.L.C.** I irrevocably assign, instruct and direct the above named Insurance Company to pay by check issued, and mailed, directly to:

FOSTER Family & Sports CHIROPRACTIC, L.L.C.
207 West Union Ave.
Bound Brook, New Jersey 08805

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the -check to our office and mail it as follows:

c/o FOSTER Family & Sports CHIROPRACTIC, L.L.C.
207 West Union Ave.
Bound Brook, New Jersey 08805

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 payment will not exceed my indebtedness to the above -mentioned assignee. I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claims by **FOSTER Family & Sports CHIROPRACTIC, L.L.C.** to be released to **FOSTER Family & Sports CHIROPRACTIC, L.L.C.** I irrevocably authorize **FOSTER Family & Sports CHIROPRACTIC, L.L.C.** to file insurance claims on my behalf for services rendered to me. I irrevocably authorize **FOSTER Family & Sports CHIROPRACTIC, L.L.C.** to act in my behalf and report any suspected violations of proper claim practices to the proper regulatory authorities.

This is a direct and irrevocable assignment of my rights and benefits under this policy. This assignment of benefits has been explained to my full satisfaction, and I understand its nature and effect.

_____ _____
Signature of Policyholder/Patient Date

_____ _____
Signature of Claimant/Patient Date

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