30 Harrington Avenue
Westwood, NJ 07675-1822
(201) 664-6000

ASSIGNMENT OF INSURANCE BENEFITS

Patient Name: _____

Insured Name: _____

Employer: _____

Claim / Group #: _____ Insured SS #: _____

I hereby instruct and direct _____
to pay by check made out and mailed directly to:

DR. LAWRENCE O'CONNOR, DC
DR. JAMES O'CONNOR, DC
O'CONNOR FAMILY WELLNESS
30 HARRINGTON AVENUE
WESTWOOD, NJ 07675-1822

If my current policy prohibits payment to doctor, then I instruct you to ake the check out to me, and mail it as follows:

C/O O'CONNOR FAMILY WELLNESS
30 HARRINGTON AVENUE
WESTWOOD, NJ 07675-1822

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 agree to pay, in a current manner, any balance of said professional service which has accrued over and above any insurance payment.

A PHOTO COPY OF THIS ASSIGNMENT SHALL BE CONSIDERED
AS EFFECTIVE AND VALID AS THE ORIGINAL

I authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

Date: _____ Signature of Patient
Or Legal Guardian: _____

Date: _____ Signature of Witness: _____