DR. MICHAEL VAJDA

761 Washington Street
Middletown, Connecticut 06457

Phone 860-343-0222
Fax 860-343-0222

ASSIGNMENT OF BENEFITS AND INTENT TO PAY DOCTOR

I hereby assign all my medical benefits available for the services rendered below to the undersigned doctor. I do direct payment of these services to his office address.

I also authorize the information necessary to process this claim to be released to the company processing this claim. This same information can not be released to an outside consultant working to evaluate my claim without my expressed written consent.

I also acknowledge that I am wholly responsible for any difference in payment between the insurance benefits and the total health care bill for the services being rendered. I have agreed with this provider of health care to make payment to him on this balance of aforementioned services.

Photocopies of this 'Assignment of Benefits and Intent to pay the Doctor' are considered to be as true and correct as the original agreement drafted by both doctor and patient.

_____
Signature of Patient

_____
Print Patients Name

_____
Date

_____
Signature of Doctor

Michael Vajda D.C.

_____
Date