Assignment of Benefits (AOB)

This AOB form is required to bill on your behalf!

My signature and date in the box below authorizes each of the following:

1. Assignment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits to Synergy Integrated Healthcare/Synergy Chiropractic Health for medical supplies and/or medication(s) furnished to me by Synergy Integrated Healthcare/Synergy Chiropractic Health.

2. Direct billing to Medicare, Medicaid, Medicare Supplemental or other insurer(s).

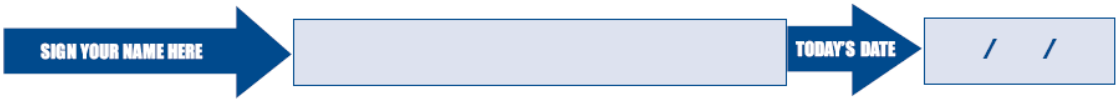
3. Release of my medical information to Medicare, Medicaid, Medicare Supplemental or other insurers and their agents and assigns.

4. Synergy Integrated Healthcare/Synergy Chiropractic Health to obtain medical or other information necessary in order to process my claim(s), including determining eligibility and seeking reimbursement for medical supplies and/or medication(s) provided.

5. Synergy Integrated Healthcare/Synergy Chiropractic Health to contact me by telephone or mail regarding my medical supplies and/or medication(s) order.

I agree to pay all amounts that are not covered by my insurer(s) including applicable co-payments and/or deductibles for which I am responsible.

Your Phone # ( )



I request that payment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits be made on my behalf to Synergy Integrated Healthcare/Synergy Chiropractic Health for any medical supplies and/or medications furnished to me by Synergy Integrated Healthcare/Synergy Chiropractic Health. I authorize any holder of medical information about me to release to Synergy Integrated Healthcare/Synergy Chiropractic Health, my physician(s), caregiver, CMS, its agents and to my primary and/or other medical insurer any information needed to determine or secure eligibility information and/or reimbursement for covered services. I agree to pay all amounts that are not covered by my insurer(s) and for which I am responsible.

I _____ appoint _____ to act as
(name of beneficiary) (name of representative)
my personal representative with Medicare, Medicaid or private insurance.

Their relationship to me is spouse, child, parent, sibling, other _____.
(choose one) (or write in)

The reason I cannot sign is: _____.
(list reason)

My representative does or does not live with me. (choose one)
If not, their address and phone number is:
Address: _____ Phone: _____

City/St/Zip: _____

Signature: _____ Date: _____
My signature and date above authorizes the above named person to sign on my behalf.