Dr. Eva Turner 10 East 704th St, Orangeburg NY 10962 845-359-5599

SIGN OVER INSURANCE CHECK AGREEMENT

I, _____ agree to sign over all insurance checks that I
(Patient's name)
receive from my insurance company for chiropractic care to Dr.Eva Turner within two weeks of receiving the check.

If I don't mail the check or the insurance company does not reimburse the visits, I understand that it is my responsibility to pay upon receipt of the insurance denial. I will pay my deductible and copays at the time services are rendered.

Patient name_____

Patient address_____

Patient signature_____

Date_____

Doctor's name: Dr. Eva Turner

Doctor's signature_____