ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR

INSURANCE COMPANY: _____
PATIENT NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
EMPLOYER: _____
CLAIM or GROUP #: _____
SS or ID #: _____

I hereby instruct the above named insurance company to pay by check made out to and mailed directly to:

FAMILY CHIROPRATIC CENTER
2801 WATERMAN BLVD. STE. 260
FAIRFIELD CA 94534

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

FAMILY CHIROPRATIC CENTER
2801 WATERMAN BLVD. STE. 260
FAIRFIELD CA 94534

For 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 fees for non-covered services and/or fees, over and above the insurance payment or as required by my insurance policy.

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

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney for the purpose of securing payment under this policy of insurance.

_____ _____
Signature of Policy Holder **Date**