

**ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR  
PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE**

Patient Name: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Claim/Group #: \_\_\_\_\_  
SS #/ID #: \_\_\_\_\_

I hereby instruct and direct the \_\_\_\_\_ Insurance Company to pay by check made out to and directly mailed to:

**DELTA CHIROPRACTIC  
43 W. ACORN LANE  
LAKE IN THE HILLS, IL. 60256**

For professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward 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 have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees over and above the insurance payment or as required by my insurance policy.

**A photocopy of the Assignment shall be considered as effective and valid as the original.**

I hereby authorize any plan administrator or fiduciary, insurer and/or attorney to release to such doctor and/or clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and/or clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby convey to the above named doctor and/or clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee healthcare plan, any claim or other right I may have to such insurance and/or employee healthcare benefit coverage under any applicable insurance policies and/or employee healthcare plan with respect to medical expenses incurred as a result of the medical services I received from the above doctor and/or clinic and the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies.

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

Dated at: \_\_\_\_\_ County, this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_

\_\_\_\_\_  
Signature of Policyholder

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Signature of claimant, if other than Policyholder