

Medical Insurance Information

Date: _____

Patient: _____

Employer: _____

Claim Group: _____

SS# / ID#: _____

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to: Fisher Family Chiropractic, 2115 Green Vista Dr. #102, Sparks NV 89431

or if my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows: Fisher Family Chiropractic, 2115 Green Vista Dr. #102, Sparks NV 89431

for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the 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 service charges over and above this insurance payment.

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 involved in this case. I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated: _____

Signature of Policyholder
Signature of Claimant, if other than Policyholder

Witness

Personal Injury (Auto Accident Insurance Information)

Insurance Companies

Your Ins. Co. _____ Policy# _____ Agent's Name _____

Name on Policy (if other than self) _____ Policy # _____

Responsible Party's Name _____

Address _____ City _____ State _____ Zip _____

Policy Holder's Name _____ Policy # _____

Attorney

Name _____ Phone () _____

Address _____ City _____ State _____ Zip _____