ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR

RELEASE OF MY MEDICAL RECORDS FROM OR FOR THE RELEASE OF MY MEDICAL RECORDS TO DUNNE CHIROPRACTIC & WESTMONT PHYSICAL THERAPY

I, _____, HEREBY AUTHORIZE THE RELEASE OF MY X-RAYS/MEDICAL RECORDS AT DUNNE CHIROPRACTIC & WESTMONT PHYSICAL THERAPY TO

I, _____, HEREBY AUTHORIZE

_____

TO RELEASE MY MEDICAL RECORDS/X-RAYS TO DUNNE CHIROPRACTIC & WESTMONT PHYSICAL THERAPY AT 315 WEST 63RD STREET, WESTMONT, IL 60559.

I HEREBY INSTRUCT AND DIRECT THE _____ INSURANCE COMPANY TO PAY BY CHECK MADE OUT AND MAILED DIRECTLY TO:

OR

IF MY CURRENT POLICY PROHIBITS DIRECT PAYMENT TO DOCTOR, THEN I HEREBY ALSO INSTRUCT AND DIRECT YOU TO MAKE OUT THE CHECK AND MAIL IT AS FOLLOWS:

C/0 DUNNE CHIROPRACTIC & WESTMONT PHYSICAL THERAPY
315 WEST 63RD STREET
WESTMONT, IL 60559

For the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment towards 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 assignee, and I agree 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, medical or chiropractic office, or attorney involved in this case.

Dated this _____ day of _____, 20_____.

SIGNED _____ WITNESSED _____

SIGNATURE OF CLAIMANT, if other than policyholder _____

DATE OF BIRTH _____ SSN _____

DUNNE CHIROPRACTIC
315 WEST 63RD STREET
WESTMONT, IL 60559
(630) 968-6969