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

Patient Name: ____

Employer: ____

Claim / Group#: ____

Social Security#/ID#: ____

I hereby instruct and direct the ___________________________________ insurance company to pay by check made out to and mailed to:

SANTA CLARA CHIROPRACIC CENTER
BELLA DELYAEI, D.C., Q.M.E.
2265 EL CAMINO REAL, SUITE 1
SANTA CALRA, CA 95050

OR

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

C/O

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 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 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 claim.

Dated at Santa Clara County, this ____________________ day of ______________________, 20______

____ ______________________________

Signature of Policyholder Witness

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Signature of Claimant, if other than Policyholder