

**Assignment and Instruction for Direct Payment to Doctor by Private and/or Group Health Insurance**

Patient: \_\_\_\_\_

ID# \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Grp/plan#: \_\_\_\_\_

I hereby instruct and direct that \_\_\_\_\_ insurance company make payment by check made out and mailed to:

REISTERSTOWN FAMILY CHIROPRACTIC  
410 MAIN STREET  
REISTERSTOWN, MD 21136

Or

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

C/O REISTERSTOWN FAMILY CHIROPRACTIC  
410 MAIN STREET  
REISTERSTOWN, MD 21136

For the medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward my medical charges. **THIS IS AN IRREVOCABLE DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed nay indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said medical service charges over and above this insurance payment.

I also authorize the release of any information pertinent to my case to any insurance company, adjustor, or attorney involved in this case. I understand that this authorization shall not obligate REISTERSTOWN FAMILY CHIROPRACTIC / HOWARD M. LIPMAN, DC irrespective of whether any insurance carrier fails or refuses to make payment.

I understand that failure or refusal to pay the full amount of my account balance with this office may result in my account being referred for collection purposes. In this event, I will be responsible for all pre-judgment interest at 12% per annum, collection company fees, reasonable attorney's fees, court cost and related fees, and post-judgment interest at the legal rate.

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

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Signature of Policy Holder

\_\_\_\_\_  
Date