BRINK CHIROPRACTIC CLINIC

William G. Brink DC
Daniel A. Brink DC
Jennifer J. McBride DC
Christopher P. Raschella DC

1047 Main St.
Sanford, ME 04073
Phone: 207-324-5753
Fax 207-324-8354

Patient Name ______________________________________

For your convenience and to expedite payment by your insurance company, we ask that you would kindly sign the Assignment authorization form below. This authorizes your insurance company to forward payments directly to us. Your statement will reflect any insurance payments.

ASSIGNMENT FOR DIRECT PAYMENT TO BRINK CHIROPRACTIC CLINIC

I, _______________________________________, hereby direct __________________________________

(patient name printed) (Insurance company name)

to pay by check payable to and mailed directly to BRINK CHIROPRACTIC CLINIC as indicated in the Claim form. Or, in the event my policy prohibits payments made directly to doctors, then I hereby direct you to make checks payable to me and mail payment to the Clinic address on the Claim. I authorize the professional expense benefits allowable and otherwise payable to me under my insurance policy as payment toward 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 BRINK CHIROPRACTIC CLINIC, and I have agreed to pay, in a current manner, any balance of charges over and above this insurance payment. A photocopy of this Assignment as addressed to me shall be considered as effective and valid as the original. I also authorize the release of any pertinent information to any insurance company, adjuster, or attorney involved.

Dated ___________________________________

Patient Signature ____

Witness _______________________________________

Thank for your prompt attention to this matter