# <u>Assignment and Authorization to Pay Doctor</u>

I hereby authorize, assign, and direct the insurance (Insurance Co.)_________
____________________________________________________

to pay directly by check made out and mailed to: **Action Chiropractic**
**1501 Pottery Ave**
**Port Orchard, WA 98366**
**(360) 876-6865**

My expense benefits for any professional services from on going care rendered or at the time of my settlement with the aforementioned insurance company otherwise payable to me directly. This payment shall not exceed my indebtedness to the above mentioned assignee.

The assignment of funds payable to me for the services rendered by the above mentioned assignee takes priority over any and all future agreement I make with aforementioned insurance carrier and specifically assigns, directs, and holds liable said insurance carrier to assure the above doctor/clinic is paid for total treatment charges on the receipt of billing services rendered or at the time of settlement **<u>by payment directly from the insurance carrier to the doctor/clinic.</u>** Futhermore, this assignment and authorization takes priority and supersedes any document signed by me and the insurance carrier which excuses the insurance carrier from liability for payment of health care cost at the above clinic.

Any document which permits the above insurance carrier to pay to me any sums for the services rendered by the above mentioned doctor/clinic is hereby declared invalid, illegal and contrary to my wishes, and does not excuse liability on the part of the insurance carrier for the direct payment of those total and ongoing costs of my care.

I fully understand that I am directly and fully responsible to said doctor/clinic for all the chiropractic bills submitted by the doctor/clinic for services rendered to me, and that this agreement is made solely for the said doctors/clinic additional protection and in consideration of his/her awaiting payment. And I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fee.

**Date: _______ Patient/Guardian's Signature:_____________________**

**Witness: __________________________**

**Original to Patient file. Copy to Insurance Carrier and Attorney.**