

# **RASMUSSEN CHIROPRACTIC CENTER, P.C.**

## **ASSIGNMENT AND INSTRUCTIONS FOR DIRECT PAYMENT TO DOCTOR PRIVATE AND GROUP ACCIDENT OR HEALTH INSURANCE**

I hereby instruct and direct \_\_\_\_\_ Insurance Company  
to pay by check made out and mailed directly to:

RASMUSSEN CHIROPRACTIC CENTER, P.C.  
200 East Lanier Avenue  
Fayetteville Georgia 30214

or

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

c/o RASMUSSEN CHIROPRACTIC CENTER, P.C.  
200 East Lanier Avenue  
Fayetteville Georgia 30214

for the professional or medical expenses/benefits allowable and otherwise payable to me  
under my current insurance policy as payment toward the total charges for the professional  
services rendered. This payment will not exceed my indebtedness to the above mentioned  
assignee and I agree to pay, in current manner, any balance of said professional service charges  
over and above this insurance payment according to the financial policy of the above assignee.

A photo copy 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 case.

THIS AUTORIZTION AND ASSIGNMENT TO THE DOCTOR LISTED ABOVE SHALL BE IRREVOCABLE  
FOR THE FULL EXTENT OF MY TREATMENT BY SAID DOCTOR AND UNTIL SUCH TIME THAT MY  
MEDICAL EXPENSES INCURRED HAVE BEEN PAID IN FULL.

\_\_\_\_\_  
Signature of Policyholder or Claimant

\_\_\_\_\_  
Date