

**ASSIGNMENT AND INSTRUCTION FOR
DIRECT PAYMENT TO DOCTOR**

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Employer: _____

Claim or Group # _____

SS# or ID# _____

I hereby instruct the above named Insurance Company to pay by check made out to and mailed directly to:

**RIEBESSELL CHIROPRACTIC CENTER INC.
1001 CROSSPOINTE DRIVE
SUITE 1
NAPLES, FLORIDA 34110-0946
239-592-0304
Tax Id. 200666257**

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 A 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 for the purpose of securing payment under this policy of insurance.

X Dated in Collier County, on _____ 20 _____

X _____
Signature of Policy Holder

Witness

Signature of Claimant, if other than Policyholder