

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

I hereby instruct and direct my insurance or the insurance of the party at fault to pay by check made out and mailed directly to:

Kapsner Chiropractic Centers
3005 S. Lamar, Ste D112
Austin, TX 78704

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 total account balance to the above-mentioned assignee and I have agreed 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. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I agree that I am ultimately responsible for the cost of any and all services rendered to me. I permit this office to endorse co-issued remittances for the conveyance of credit to my or the at fault person's insurance company to pay Kapsner Chiropractic directly from any settlement payment.

I hereby authorize and permit any doctor or any other representative of Kapsner Chiropractic to contact any and all physicians, hospitals, clinics, pharmacies or other providers of medical services or products that have examined, treated or provided medical services or products to me at any time. I request said physicians, hospitals, clinics, pharmacies or other providers of medical services or products to furnish said person(s) full and complete reports covering the nature and extent of the treatment given or services and products provided and all information relative to my physical condition, past, present and future. This will also authorize said person(s) to obtain copies of all x-rays or x-ray reports, hospital records, narrative reports, lab tests, nurses notes and prescriptions.

I also authorize the release of any information pertinent to my case to any insurance company, adjustor or attorney involved in this case. **THIS AUTHORIZATION AND ASSIGNMENT OF BENEFITS TO THE PROVIDER 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.**

A PHOTOCOPY OF THIS ASSIGNMENT AND AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

Signature of Policy Holder

Date

Signature of Claimant IF other than Policy Holder

Date

Witness