



Colgin Chiropractic Clinic

Tel 512-396-2662 Fax 512-395-8700

ASSIGNMENT OF BENEFITS

DATE _____

Patient's Name _____

Employer _____

Claim Group _____

SS#/ID# _____

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to:

James E. Colgin, D. C.
1101 Thorpe Lane, Suite E
San Marcos, TX 78666

For professional or medical benefits allowable and otherwise payable to me under current insurance policy as payment toward the total charges for the 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 service charges over and above this insurance payment.

A photocopy of the original shall be considered as valid as the original.

I also authorize the release of any information pertinent to my care to any insurance company, adjuster, or attorney involved in this case.

I authorize doctor to initiate a complaint to the Insurance Company for any reason on my behalf.

Sign in presence of witness:

Dated at Colgin Chiropractic Clinic this _____ day of _____

Signature of Policyholder

Witness

Signature of Claimant if other than Policyholder