

Sikorsky Chiropractic Clinic, S.C  
1425 N. McLean Blvd, Unit 700  
Elgin, IL 60123

Date \_\_\_\_\_

Patient: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Claim #/Group#: \_\_\_\_\_  
SS#/ID#: \_\_\_\_\_

I hereby instruct and direct \_\_\_\_\_ Insurance Company/fun to pay by check made out and mailed to: **Sikorsky Chiropractic Clinic, SC, 1425 N McLean Blvd, Elgin, IL 60123, 847-695-0464**

If my current policy prohibits direct payments to the doctor, I hereby also instruct and direct you to make out the check to mail and mail as follows:

**Sikorsky Chiropractic Clinic, SC, 1425 N McLean Blvd, Elgin, IL 60123, 847-695-0464**

For the professional or medical benefits allowable, and otherwise payable to me under my current insurance / health benefits 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.

I hereby also instruct and direct you to recognize Sikorsky Chiropractic Clinic, SC and its employees as my designated authorized representative. If this is not in accordance with plan procedures, please forward an explanation of such procedures and any necessary forms by facsimile addressed to me at 847-695-0461. I hereby also instruct and direct you to send any forms necessary to the processing of a claim to me at the above address or fax number.

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

I authorize the doctor to initiate a complaint to the Insurance Commissioner or U.S. Department of Employment Security, for any reason on my behalf.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Dated this \_\_\_\_\_ day of, 20\_\_\_\_\_

\_\_\_\_\_  
Signature of Claimant,  
If other than the policy holder

\_\_\_\_\_  
Witness