Clock Tower Chiropractic & Massage
9375 SW Commerce Circle, Suite A100
Wilsonville, OR 97070
Ph: 503-685-9841 F: 503-682-9069
colby@wilsonvillechiropractor.com

ASSIGNMENT FOR DIRECT PAYMENT

Patient's Name: _____

Insurance Company: _____

Insurance Telephone: _____

Group/Plan/Claim #: _____

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

Dr. Sarah Colby, Chiropractic Physician
9375 SW Commerce Circle, Suite A100
Wilsonville, OR 97070

As a courtesy, we will be happy to check your insurance benefits and inform you of our findings. **Benefits quoted are not a guarantee of coverage.** Ultimately, it's your responsibility as the patient to know your own coverage and benefits. We strongly encourage you to call your insurance company or refer to your benefits manual to confirm you are covered for the services. If you have any questions, please contact the front office.

For professional or chiropractic 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 of non-covered services and/or fees over and above the insurance payment or as required by my 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 involved in this claim.

PATIENT'S SIGNATURE: _____ DATE: _____