AUTHORIZATION TO PAY DOCTOR

INSURANCE COMPANY:_____
ADDRESS:_____

RE: _____
SSN: _____

GROUP: _____
EMPLOYER_____

I hereby authorize the above named insurer to pay by check made out and mailed to

Sorrento Valley Chiropractic
5440 Morehouse Dr #1700
San Diego, CA 92121

The expense benefit allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered. This payment shall not exceed my indebtedness to above mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charge over and above this insured payment.

NAME:_____ADDRESS:_____
_____
_____

_____ _____
SIGNITURE OF PATIENT DATE