AUTHORIZATION TO PAY DOCTOR

I hereby authorize the _____
(name of Insurance Company) to pay by check made out and mailed directly to:

Nielsen Chiropractic Health Center
1502 Oklahoma Avenue
Woodward, OK 73801

The expense benefits 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 named 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 understand that Nielsen Chiropractic Health Center will file insurance claims as a courtesy to the patient. It is my responsibility as the patient to monitor payments made by the insurance company. If insurance is not paying, it is my responsibility as the patient to acquire the necessary payment whether it be by contacting the insurance company, hiring an attorney, or personally paying the balance myself. I realize that Nielsen Chiropractic Health Center cannot hire an attorney to represent me. If a payment has not been received, Nielsen Chiropractic Health Center may contact me so that further action can be taken. In some cases a Physicians Lien may be warranted.

_____ _____
(Signature)

_____
(Do not write in this space; for office use only.) (Name)

Policy No. _____ _____
(Street Address)

Agent _____ _____
(City, State)

Claims Office Address _____
(Date)