Assignment and Authorization

Private/Group/Accident/Health Insurance

I hereby request _____ to send payment directly to the indicated physician at the following address:

Crown Hill Chiropractic
Kevin Waugh, D.C.
9776 Holman Rd NW #109
Seattle, WA 98117
(206)782-8800

I specifically authorize that this assignment may be paid from any benefits due me under this claim, either from medical payments, disability benefits or both. I understand and agree that any unpaid balances not covered by this policy will be paid by me.

I also authorize Crown Hill Chiropractic Center to release or obtain/request any information relating to my case to or from any insurance co., adjustor, or attorney in the case.

Dated this _____ day
Of _____, 20_____

_____
Signature of Policy Holder

_____
Signature of Claimant, If other than Policy Holder