DC Chiropractic Center

DANIEL O. COOK, D.C.

1765 State St.
Salem, OR 97301
Phone: 503-585-2585
Fax: 503-588-4133

Assignment of Insurance Benefits

Patient Name _____ Date of Birth _____
Address _____
City _____ State _____ Zip Code _____

Health Insurance

Insurance Company _____
ID Number _____ Group Number _____

Secondary Insurance *(if applicable)*
Insurance Company _____
ID Number _____ Group Number _____

Auto/Work Injury

Insurance Company _____ Date of Injury _____
Policy Number _____ Claim Number_____

I hereby authorize Daniel O. Cook, D.C. to furnish my insurance company all information, which it requests, concerning my present claim. I assign to Daniel O. Cook, D.C. all money to which I am entitled for all services that they have performed related to this claim. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** It is understood that any money received by Daniel O. Cook, DC that exceeds my indebtedness to Daniel O. Cook, D.C. will be fully refunded to me when my bill is paid in full. I understand that I am financially responsible and liable for any expenses that are not reimbursed by my insurance company.

I hereby instruct and direct _____ Insurance Company to pay by check, made out and mailed to: Daniel O. Cook, D.C., 1765 State St. Salem, OR 97301.

OR

If my current policy prohibits direct payment to the doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows _____
(Name of Patient)

C/O Daniel O. Cook, D.C., 1765 State St. Salem, OR 97301.

A photocopy of this Agreement shall be considered as effective and valid as the original.
I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

_____ _____
Signature of Policyholder Date

_____ _____
Signature of Claimant, if other than Policyholder Date