Downs Chiropractic, Inc.
James E. Downs, D.C., D.A.B.C.O.
Board Certified in Chiropractic Orthopedics

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INSURANCE AUTHORIZATION AND ASSIGNMENT

SIGNATURE ON FILE

I ACKNOWLEDGE my current health insurance carriers are as follows:

1)_____

ID #: _____ Group #:_____

2)_____

ID #: _____ Group #:_____

3)_____

ID #: _____ Group #:_____

I AUTHORIZE _____, my primary insurance carrier, to make direct payment to Dr. Downs according to my individual insurance plan. I understand that I am responsible for any portion not covered by that plan.

I AUTHORIZE my doctor to act as agent in assisting me to obtain payment as well as to release any necessary information regarding my treatment to the above-named insurance carrier.

I AUTHORIZE the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to me or to the party who accepts assignment below.

Authorization is applicable to all services rendered until specifically revoked. Copies of original may be utilized.

Name_____
Please print

Signature_____Date_____