

**ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR  
PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE**

**RE:**

**Patient:** \_\_\_\_\_

**Employer:** \_\_\_\_\_

**Claim/Group #:** \_\_\_\_\_

**SS#/ID#:** \_\_\_\_\_

**I hereby instruct and direct the** \_\_\_\_\_

**Insurance Company to pay by check made out and mailed directly to:**

**Grunewald Chiropractic &  
Natural Medicine Clinic, Ltd.  
1630 S. Galena Ave., Suite A  
P.O. Box 754  
Freeport, IL 61032**

**If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:**

**c/o Grunewald Natural Medicine, Ltd.  
1630 S. Galena Ave., Suite A  
P.O. Box 754  
Freeport, IL 61032**

**the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.**

**A photocopy of this Assignment shall be considered as effective and valid as the original.**

**I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.**

**Dated at Grunewald Natural Medicine Clinic, Ltd**

**This \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_**

\_\_\_\_\_  
**Signature of Policyholder**

\_\_\_\_\_  
**Witness**

\_\_\_\_\_  
**Signature of Claimant, if other than policyholder**