



Date: ____/____/____

Date of Birth: ____/____/____

Patient Name: _____

Address: _____

City, State Zip _____

CHIROPRACTIC
ACUPUNCTURE
DIAGNOSTIC IMAGING
REHABILITATION

PERSONAL INJURY ATTORNEY/INSURANCE:

Med-Pay Carrier: _____ Phone #: _____

Carrier Address: _____ City, State Zip: _____

Policy #: _____ Claim #: _____ Med-Pay Amount: _____

Insured Name: _____ Insured SS# _____

Attorney Name: _____ Phone # _____

Address _____ City, State Zip _____

Date of Injury: _____ Patients Phone Number: _____

GROUP/PRIVATE INSURANCE:

Insured Name: _____ Insured SS#: _____

Insured's Employer: _____ Employer Address: _____

Insurance Carrier: _____ Address: _____

Phone #: _____ Contact Person: _____

Group #: _____ Policy #: _____

WORKERS' COMPENSATION INSURANCE:

W/C Carrier Name: _____ Phone # _____

Carrier Address: _____ City, State Zip: _____

Employer Name: _____ SS# _____ Phone # _____

Employer Address: _____ City, State Zip: _____

Date of Accident: _____ Claim #: _____ Adjuster: _____

ASSIGNMENT OF BENEFITS

I hereby instruct the _____ Insurance Co. to pay by check made out to and mailed directly to: **Diagnostic Imaging 16200 E. Amber Valley Drive Whittier, CA 90604**. 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: **Diagnostic Imaging 16200 E. Amber Valley Drive Whittier, CA 90604** for 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 current manner any balance and/or Co-pay of said professional service charges over and above this insurance payment.

Date: _____ Signed: _____ (Patient or Insured)

Doctors Please Include a Diagnosis Code Here _____