INSURANCE ASSIGNMENT AND RELEASE

SAMUEL GORDON DC
4101 IH 69 ACCESS RD SUITE M-5
CORPUS CHRISTI, TEXAS 78410

AUTHORIZATION TO RELEASE INFORMATION

I, the undersigned, authorize Samuel Gordon D.C. or any member of his staff directed by him to use my health care information and may disclose such information to the insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed.

ANY COPY OF THIS INSTRUMENT IS DEEMED TO BE CONSIDERED AS AN ORIGINAL:

SIGNED: _____
(DATED AND WITNESSED SAME AS BELOW)

MAKE PAYMENT DIRECTLY TO THE DOCTOR

I hereby authorize and request that all insurance companies involved in the distribution of funds regarding my health care make the checks payable to and mail directly to:

FIVE POINTS CHIROPRACTIC
4101 IH 69 ACCESS RD M-5
CORPUS CHRISTI, TEXAS 78410

These payments will not be over the amount I owe in charges at Five Points Chiropractic. If the amount paid by the insurance company is not enough to pay my bill in its entirety, I promise to pay the remaining balance within 30 days of notification.

I AGREE NOT TO REVOKE THIS AGREEMENT.

SIGNED: _____

DATE: _____ WITNESS: _____