Dr. Brooke M. Breitbach, DC
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DIRECT ASSIGNMENTS OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION

Patient: _____ Social Security No. _____

Insured Name _____ Insured's Date of Birth: _____

☐ I do NOT have insurance and understand that I am personally responsible for all charges for services rendered by Brookview Wellness.

☐ I have insurance with _____ insurance company and hereby instruct and direct said insurance company to pay by check made out and mailed to the address above.

If my current policy prohibits direct payment to the doctor, I hereby also instruct and direct you to make out the check to the address above for the professional expense and benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the 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.

I understand that filing insurance does not guarantee payment and if payment is not made within 90 days by my insurance, the balance due is my responsibility.

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

I authorize this doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

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

_____ _____
Printed Name of Patient **Printed** Clinic Representative

_____ _____
Signature of Patient **Signature** of Clinic Representative
(or parent/legal guardian, as applicable)

_____ _____
Date: Date: