SPRING GROVE
PHYSICAL MEDICINE
& REHABILITATION

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

RE:

Patient: _____
Employer:_____
Claim/Group Number (if Medicare NONE):_____
SS#/ID#_____

I hereby instruct and direct the _____
Insurance Company to pay by check made out and mailed directly to:

Spring Grove Physical Medicine & Rehabilitation
2100 Route 12, Suite 100
Spring Grove, IL 60081

OR

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

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 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 Spring Grove Physical Medicine and Rehabilitation, LTD.

_____ _____

Signature of Policyholder Witness

_____ _____

Signature of Claimant Date