

**ASSIGNMENT AND INSTRUCTION FOR  
DIRECT PAYMENT TO DOCTOR**

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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

Claim or Group # \_\_\_\_\_

SS# or ID# \_\_\_\_\_

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

**RIEBESSELL CHIROPRACTIC CENTER INC.  
1001 CROSSPOINTE DRIVE  
SUITE 1  
NAPLES, FLORIDA 34110-0946  
239-592-0304  
Tax Id. 200666257**

for 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 fees for non-covered services and/or fees, over and above the insurance payment or as required by my insurance policy.

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 for the purpose of securing payment under this policy of insurance.

Dated in Collier County, on \_\_\_\_\_ 20 \_\_\_\_\_

\_\_\_\_\_  
Signature of Policy Holder

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Signature of Claimant, if other than Policyholder