

**ASSIGNMENT OF BENEFITS AND RESPONSIBILITY OF PAYMENT
PLEASE COMPLETE AND SIGN THE FOLLOWING:**

I HEREBY INSTRUCT THE _____ INSURANCE CO. TO PAY BY CHECK MADE OUT TO AND MAILED DIRECTLY TO :

MCFARLAND CHIROPRACTIC GROUP, INC.

- DR. LORNE S. MCFARLAND, D.C.
 DR. FARNAZ SHAYGAN, D.C.

**1216 E. YORBA LINDA BLVD.
PLACENTIA, CA 92870**

IF MY CURRENT POLICY PROHIBITS DIRECT PAYMENTS TO THE DOCTOR, THEN I HEREBY ALSO INSTRUCT AND DIRECT YOU TO MAKE OUT THE CHECK TO ME AND MAIL IT AS FOLLOWS:

MCFARLAND CHIROPRACTIC GROUP, INC.

- DR. LORNE S. MCFARLAND, D.C.
 DR. FARNAZ SHAYGAN, D.C.

**1216 E. YORBA LINDA BLVD.
PLACENTIA, CA 92870**

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, DEDUCTABLE, AND/OR CO-PAY OF SAID PROFESSIONAL SERVICE CHARGES OVER AND ABOVE THIS INSURANCE PAYMENT.

I FURTHER UNDERSTAND THAT I WILL BE RESPONSIBLE FOR PAYMENT TO ANY OTHER FACILITIES AND/OR HEALTHCARE PROVIDERS THAT I MAY BE REFERRED TO BY **MCFARLAND CHIROPRACTIC GROUP, INC. OR ABOVE MENTIONED DOCTOR** AND ANY EMERGENCY TRANSPORTING THAT MAY BE REQUIRED THERETO. I ALSO AUTHORIZE THE RELEASE OF ANY INFORMATION PERTINENT TO MY CASE TO ANY INSURANCE COMPANY, ADJUSTER, OR ATTORNEY INVOLVED IN THE CASE.

THIS OFFICE WILL GLADLY PREPARE INSURANCE FORMS AND REPORTS; HOWEVER, WE CANNOT RENDER SERVICES ON THE ASSUMPTION THAT OUR CHARGES WILL BE PAID BY THE INSURANCE COMPANY OR ATTORNEY SETTLEMENT. ALL PROFESSIONAL SERVICES ARE CHARGED DIRECTLY TO THE PATIENT, THEREFORE BASIC RESPONSIBILITY FOR PAYMENT IS YOURS.

_____(INITIAL) I HEREBY ACKNOWLEDGE AND UNDERSTAND THAT IN THE EVENT THAT I DO NOT HAVE INSURANCE THAT COVERS CHIROPRACTIC SERVICES OR PRODUCTS THAT ALL SERVICES AND PRODUCTS ARE PAYABLE WHEN TREATMENT IS RENDERED AND THAT BASIC RESPONSIBILITY FOR PAYMENT IS MINE. I FURHTER UNDERSTAND THAT IF I AM DELINQUENT ON MY OBLIGATION TO PAY **MCFARLAND CHIROPRACTIC GROUP, INC.** THAT I WILL BE RESPONSIBLE FOR ANY LATE FEES, INTERST CHARGES, COURT COST, ATTORNEY FEES, AND COLLECTION CHARGES SHOULD THE BALANCE NOT BE PAID IN DUE DILIGENCE.

NAME: _____ DATE OF BIRTH: _____

SOCIAL SECURITY # : _____ DRIVERS LICENSE#: _____

DATE: _____ SIGNED _____ (PATIENT, PARENT, GUARDIAN)