Assignment and instruction for

DIRECT PAYMENT to DOCTOR

Private, Group and Third Party Accident and/or Health Insurance.
This is an irrevocable assignment of benefits for services already rendered.

Patient and /or Plaintiff_____
Employer or Defendant_____
Claim or Group #_____
SS# and/or ID# of policyholder_____DOI:_____

I hereby instruct and direct_____Insurance Company, (if third party as part of my settlement), to pay by check payable directly to, and mailed directly to;

Castiglione Chiropractic Centers, Inc.
Dr. Frank A. Castiglione, D.C.
8350 Archibald Ave., Ste 100
Rancho Cucamonga, CA 91730

If this is a THIRD PARTY CLAIM or my current policy for any reason will not direct payment to my doctor, then I hereby also instruct and direct you to make out the check to me for the amount of services provided by my doctor and mail to; C/O;

Castiglione Chiropractic Centers, Inc.
Dr. Frank A. Castiglione, D.C.
8350 Archibald Ave., Ste 100
Rancho Cucamonga, CA 91730

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 a current manner, any balance of said professional service charges over and above this insurance payment, which is not contingent on any settlement, judgment or verdict by which I may eventually recover.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

I also authorize Dr. Frank Castiglione and/or Castiglione Chiropractic Centers, Inc. to release any information pertinent to my case to any part, insurance company, adjuster, or attorney involved in this case.

To the Insurance Company responsible for my services,
This is a legally binding contract under the laws of California. Dr. Castiglione's office holds an assignment/lien on this case for his services rendered. He is relying upon your GOOD FAITH to honor this assignment/lien. Any settlement of this claim without honoring this assignment/lien will cause you to be responsible to his office for payments. If such action is necessary you will also be responsible for court cost and attorney fees.

Dated in California this_____Day of_____20_____
Day of the week Month Year

_____ _____
Signature of Policyholder/Patient *Witness*

_____
Signature of Claimant if other than Policyholder
(Plaintiff, Parent, Guardian)