Direct Billing Consent and Assignment Form

I herewith assign my benefits, payable from claims submitted to:

Dr. Elizabeth Koehle HBMSc., D.C, Chiropractor/Acupuncture Provider;
Dr. James Koehle, D.C Chiropractor/Acupuncture Provider;
Brianna Perry R.M.T., Registered Massage Therapist ;
Fiona Morton R.M.T., Registered Massage Therapist

And authorize my insurer to send payment directly to him or her.

I also hereby authorize the electronic transmission of all information included in my health insurance claims to my plan administrator or the administrator's designated representative.

Patient Name: _____

Date of Birth (YYYY/MM/DD): _____

Address: _____

_____

Phone Number: _____

Plan member name if not the same as above: _____

Relationship to you (Spouse, mother, father etc.) _____

Date of Birth (YYYY/MM/DD): _____

_____ Dated: _____

Signature of the patient or parent:

FILL IN INFO OR PROVIDE US WITH A COPY OF YOUR HEALTH BENEFITS CARD

Insurance Company Name: _____

Policy Number: _____

I.D. Number: _____

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