# 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;
**Dr. Brett McEwan, D.C.,** Chiropractor/Acupuncture Provider
**Brianna Perry, R.M.T.,** Registered Massage Therapist
**Vanessa Rouse, R.M.T.,** Registered Massage Therapist
**Erin Feaver 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:

Insurance Company Name: _____

Policy Number: _____

I.D. Number: _____