

SIGN OVER INSURANCE CHECK AGREEMENT

I, _____ agree to sign over all insurance checks that I
(Patient's name)
receive from my insurance company for chiropractic care to Dr.Laura Heisler
within two weeks of receiving the check.

If I don't mail the check or the insurance company does not reimburse the visits,
I understand that it is my responsibility to pay upon receipt of the insurance
denial. I will pay my deductible and copays at the time services are rendered.

Patient name _____

Patient address _____

Patient signature _____

Date _____

Doctor's name: Dr. Laura Heisler

Doctor's signature _____