AUTHORIZATION TO PAY DOCTOR

I hereby authorize _____ (Insurance Company) to pay by check made out and mailed directly to:

Heaton Chiropractic Center
1406 Beltline Road Suite A
Decatur, Al 35601

The expense benefits allowable and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered. This payment shall not exceed my indebtedness to above named assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

INFORMATION OF INSURED (CARD HOLDER)

DATE_____
NAME_____ DATE OF BIRTH_____
MAILING ADDRESS_____
CITY_____ STATE_____ ZIP CODE_____