

LIEN ASSIGNMENT  
FOR DIRECT PAYMENT TO DOCTOR

NAME OF INSURED: \_\_\_\_\_

POLICY/ GROUP #: \_\_\_\_\_

CLAIM/ID #: \_\_\_\_\_

NAME OF CLAIMANT: \_\_\_\_\_

DATE OF INJURY: \_\_\_\_\_

I hereby instruct and direct the \_\_\_\_\_  
Insurance Company to pay by check and made out and mailed directly to:

SCHROEDER FAMILY CHIROPRACTIC  
2535 N. FRESNO  
FRESNO CA 93703  
(559) 226-2535

I also authorize Schroeder Family Chiropractic to release my information pertinent to my case to any Insurance Company, adjuster, or attorney involved in this case.

A photocopy of this assignment shall be considered as effective and valid as the original.

SIGNATURE OF CLAIMANT: \_\_\_\_\_

DATED: \_\_\_\_\_

THIS AUTHORIZATION SHALL REMAIN IN EFFECT UNTIL  
CANCELLATION IS RECEIVED VIA WESTERN UNION.