THE CHIROPRACTIC CENTER OF LAS VEGAS

INFORMED RESCISSION OF ATTORNEY ASSIGNMENT OF BENEFITS

PATIENT :_____

INSURED :_____

DATE OF INJURY :_____

CLAIM #/ POLICY # :_____

SOCIAL SECURITY # :_____

I, being the insured on this policy, specifically direct you, my insurance company to rescind and cancel any assignment given to you by any third party including my attorney, EXCEPT to my physician.

Name: The Chiropractic Center of Las Vegas/ Kevin L. Kaldy, DC

Address: 311 N. Buffalo Dr. Ste.A
Las Vegas, NV 89145

As the owner and beneficiary of this policy, I further direct that reimbursement for ALL services be paid DIRECTLY to my physician, the provider of services under the terms of my contract with this company. NO other third party, including my attorney, should receive payment of my medical bills, except the treating physician for the remainder of this claim.

Thank you for your cooperation in this matter.

_____ _____

Patient Insured Signature **Date**

8821 W. Sahara Ave. Ste. 120
Las Vegas, NV 89117
Office: (702) 212-3333 Fax: (702) 212-3300