SOUTH MAIN CLINIC
12333 S MAIN
HOUSTON, TX 77035
(713) 729-7600 – Fax (713) 729-76003

NAME OF PATIENT: _____
NAME OF POLICY HOLDER: _____
DATE OF BIRTH OF POLICY HOLDER: _____
SS#/ID#:_____ GROUP: _____

With this letter I ask that _____ who is my insurance company will pay in the form of a check in the name of ''South Main Clinic" and send the check by mail to the following address:
South Main Clinic
12333 S Main
Houston, TX 77035

In case that my insurance company does not allow a direct payment to a doctor, I ask that the insurance company makes a check under my name and sends the check to:
South Main Clinic
12333 S Main
Houston, TX 77035
in order to pay for professional services and accrued medical charges in another form payable to me under my actual health insurance policy as a total payment for medical services received. Under this policy I assigned as a direct form my rights and my benefits. This payment must not exceed the benefits assigned by the insurance company mentioned above and I agree to pay the balance, if any, for medical services received that have been charged to myself or my insurance company.

The photocopy of this Agreement is considered as valid as the original.

I also authorize the release of any type of information regarding my case to any health insurance company, adjuster, or any lawyer involved in this case.
I also authorize the healthcare provider to file a claim to the Commissioner of Health Insurance policy if necessary.

I also received a copy of Notice of Private Practice Regulations. _____(Initials)

_____ _____
Policy Holder Signature Witness