

*Lucie Capek, MD, PLLC*  
713 Troy Schenectady Rd Ste 308  
Latham, NY, 12110

**Patient** \_\_\_\_\_ **Date** \_\_\_\_\_

**Policy Holder's Employer** \_\_\_\_\_

**Insurance ID #** \_\_\_\_\_ **Group #** \_\_\_\_\_

I hereby instruct and direct \_\_\_\_\_ to pay by check made out to:  
(insurance company's name)

**Lucie Capek, MD, PLLC.**

OR

If my current policy prohibits direct payment to Dr. Capek, I hereby also instruct and direct you to make out to me and mail it to the following address: **713 Troy-Schenectady Rd Ste 308 Latham, NY 12110** for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the 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.

I authorize Dr. Capek to deposit checks received on my account when made out to me.

A photocopy of this Assignment shall be considered as effective as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

I authorize Dr. Capek to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

I understand that if I receive a non-covered service, as described in my coverage, from Dr Capek, and, that if my insurance company does not pay for the non-covered service, or, I was not an eligible member at the time of service, I am responsible for the charges.

\_\_\_\_\_  
Signature of Policyholder

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Claimant if NOT Policyholder

\_\_\_\_\_  
Witness