



### AUTHORIZATION

I, \_\_\_\_\_ hereby authorize and direct my insurance company and/or my attorney to pay my medical payment directly to Pro Chiropractic Inc., dba The Brooks Clinic.

**Please mail payment directly to the following:**

Pro-Medical Inc.  
dba The Brooks Clinic  
820 N.W. 13<sup>th</sup> Street  
Oklahoma City, OK 73106

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Patient Name: \_\_\_\_\_