

AUTHORIZATION AND ASSIGNMENT

To: Family Chiropractic Clinic, P.C. (hereinafter referred to as "entity or Chiropractors").

In consideration of your understanding to treat me, I agree to the following:

AUTHORIZATION TO RELEASE INFORMATION

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you, and I hereby release you of any consequence thereof.

AUTHORIZATION TO PAY DIRECTLY TO DOCTOR

In consideration of the chiropractic services rendered and to be rendered to me, I authorize and direct the payment to you for chiropractic services of any sum I now or hereafter owe you, by my attorney directly out of the proceeds of any settlement of my case, and/or by any insurance company obligated to reimburse me for the charges for your services. This is a direct authorization to the attorney to pay such sums from funds that he/she may receive into his/her trust account in connection with my personal injury or workman's compensation case.

ACKNOWLEDGEMENT AND UNDERSTANDING

I hereby acknowledge that I am receiving (or about to receive) health care services at the Family Chiropractic Clinic, P.C., Chiropractic Offices. Such entity and chiropractors are not obligated to wait for any payment for such services more than 30 days after the date of each billing, and I am obligated to pay the full bill, with or without insurance reimbursement for all or part of such bill, within 30 days after billing or further chiropractic services do not need to be provided to me.

I understand that if it is determined either:

- a) That there is no insurance company obligated to pay for all or part of the services, or if the insurance company involved refuses to pay all or part of the chiropractic invoices; or
- b) If a liability claim for medical payments or reimbursement exists, and my attorney is unable to obtain payments from the insurance company for all or part of the chiropractic bills within a reasonable time, not to exceed 30 days after the date of billing, or if I have not engaged the services of any attorney;

Then full payment for services rendered by the Chiropractor(s) will be made by me on a current basis, and my chiropractic bills shall be paid in full by me whether or not my liability claim is then or about to be settled. In the event I default, I agree to pay, whether or not legal proceedings are INSTITUTED, A REASONABLE COLLECTION FEE WHICH SHALL BE 30% OF THE PRINCIPAL BALANCE FOR ANY DEBT INCURRED HEREUNDER AND TO PAY ALL REASONABLE ATTORNEY FEES as a result of my default.

Signed: _____ Date: _____