WELLNESS
CHIROPRACTIC
move well · eat well · be well

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ASSIGNMENT, LIEN AND AUTHORTZATION OF INSURANCE BENEFITS, AND POWER OF ATTORNEY

To Whom It May Concern:
I hereby authorize and direct you, my insurance company, and/or my attorney, to pay directly to the above-mentioned clinic/doctor, such sums as may be due and owing this Office for services rendered me, both by reason of accident or illness, and by reason of any other bills that are due this office, and to withhold such sums from any disability benefits, medical payments benefits, no-fault benefits, health and accident benefits, workmen's compensation benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect such Office. I hereby further give lien to said Office against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by said Office. This is to act as an assignment of my rights and benefits to the extent of the Office's services provided.

In the event my insurance company obligated to make payments to me upon the charges made by this Office for their services refuses to make such payments upon demand by me or the Office, I hereby assign and transfer to this Office any and all causes of action that I might have or that might exist in my favor against such company and authorize this Office to prosecute said cause of action either in my name or in the Office's name and further I authorize this Office to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

I understand that I remain personally responsible for the total amounts due the Office for their services. I further understand and agree that this Assignment, Lien, and Authorization does not constitute any consideration for the Office to await payments and they may demand payments from me immediately upon rendering services at their option.

I authorize the Office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Agreement, Lien and Authorization. I agree that the above-mentioned Office may be given Power of Attorney to endorse/sign my name on any, and all checks for payment of my doctor bill.

Date: _____

Patient: _____

Signature: _____

Witness: _____