AUTHORIZATION AND ASSIGNMENT

To Wofford Chiropractic in consideration of your undertaking 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.

Assignment of Clause of Action

In the event any insurance company is obligated by contractual agreement to make payment to me or to you for the demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is/are believed to be correctly set forth under pertinent data below) and authorize you to prosecute said action either in my name or your name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company (or companies) contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part due), I personally owe you, and agree to pay in a current manner.

Authorization to Pay Directly to Doctor

To _____

(Name of Attorney and/or Insurance Company)

In consideration of the chiropractic services rendered and to be rendered by him, I authorize and direct the payment to the doctor named above of any sum I now or hereafter owe him by you, my attorney, out of the proceeds of any settlement of my case, and/or by any insurance company obligated to reimburse me for the charges for his services or otherwise obligated to make payment to me or him based on whole or in part upon the charges made for his services. If my current policy prohibits direct payment to the doctor, then I hereby also instruct and direct you to make out the check to me and mail to as follows.

Wofford Chiropractic
267 N. El Camino Real, Ste. H
Encinitas, CA 92024

Acknowledgement and Understanding

I hereby acknowledge that I am receiving (or about to receive) healthcare services at Wofford Chiropractic, and that I have been advised that the doctor(s) providing the services is/are willing to wait for payment for these services, provided that there continues to be reasonable chance that payment will be made either by insurance proceeds or out of the settlement of a liability claim.

I understand that if it is determined either:
a) That there is no insurance company obligated to pay for the services, or if the insurance company involved refuses to acknowledge an assignment to the doctor(s) or make other provisions for the protection of the interest of the doctor(s); or

b) If a liability claim exists, and my attorney refuses to agree to protect the interest of the doctor(s), or if I have not engaged the services of an attorney;
Then payment for services rendered by the doctor(s) at the Wofford Chiropractic office will be made on a current basis and my bill paid in full as soon as my liability claim is settled or the passage of three months from my last treatment, whichever occurs first.

Date_____/_____/_____ Patient Signature _____

Witness _____