Authorization of Assignment

To West University Wellness, P.C.,
In consideration of you 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 or your staff, and hereby release you of any consequence thereof.

Assignment of Cause of Action

In the event any insurance company is obligated by contractual agreement to make payments 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 date 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 within a 60 day period from the time of service (whether it be all or part of what is 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 the doctor(s), I authorize and direct the payment to West University Wellness, P.C. of any sum I now or hereafter owe them by myself, my attorney, out of proceeds of any settlement of my case, and/or by any insurance company obligated to reimburse me for the charges for their services or otherwise obligated to make payment to me or them based in whole or in part upon the charges made for their services.

Acknowledgement and Understanding

I hereby acknowledge that I am receiving (or about to receive) health care services at West University Wellness, P.C. and that I have been advised that the doctor(s) providing services is/are willing to wait a maximum of 60 days from the time of service incurred for payment for these services, provided that there continues to be a 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:

1. 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
2. if a liability claim exists, and my attorney refuses to agree to protect the interests of the doctor(s) or if I have not engaged the services of an attorney;

Then payment of services rendered by the doctor(s) at West University Wellness, P.C. will be made on a current basis and my bill paid in full as soon as the liability claim is settled or the passage of 6 months from my last treatment, whichever occurs first.

Dated: The _____ day of _____ 20____

Patient's Signature: _____

Witness: _____