AUTHORIZATION AND ASSIGNMENT OF BENEFITS

1. You are to release any information you deem appropriate concerning my health condition to the insurance company, attorney or adjustor in order to process any claim for reimbursement of charges to doctor and/or clinic by me.

2. I authorize and assign the direct payment to you of any sum I now or hereafter owe you by my allowance out of the proceeds of any settlement of my case and by any insurance company obligated to reimburse me for the charges of your services or otherwise obligated to make payment to me or you in whole or part upon the charges made for your services.

3. I give assignment and lien against any claims against a third party whose negligence may have caused patient's injury, up to the bill of the treatment.

4. In the event any insurance company obligated by contractual agreement to make payment to me or you for the charges made for your services refuses to make such payment upon 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 believed to be correctly set forth under payment data below and authorize you to prosecute said action, either in my or your name, and further authorize you to compromise, settle or resolve said claim as you see fit. However, it is understood that after reasonable efforts have been made to collect the sums from the insurance company, I will be responsible for any and all balances.

5. I waiver the Statue of Limitations regarding my doctors right to recover.

Patient Name _____

Patient Signature_____ Date___/___/_____

Insurance Company_____

Address_____

Policy Number_____ Group Number_____

Telephone_____

Primary Holder_____ Relationship to patient_____

Address (if different from the patient)_____