

Authorization, Assignment, Acknowledgment and Understanding

AUTHORIZATION TO RELEASE INFORMATION: Atiyeh Chiropractic is authorized to release any information that it deems appropriate concerning my physical condition to any insurance company, attorney, adjuster or family member named here _____ relationship _____ in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by Atiyeh Chiropractic, including its designated associates and assistants and hereby release Atiyeh Chiropractic from any consequence and/or liability concerning the same.

ASSIGNMENT OF PAYMENT: My attorney and/or insurance company are hereby requested to pay directly to Atiyeh Chiropractic any monies due it on account, the same to be deducted from any settlement made of my behalf. Further, it is understood and agreed that I shall pay the full amount of the charges, should my condition be such that it is not covered by my insurance policy or if for any reason the insurance company and/or attorney refuses and/or fails to pay my claim.

UNPAID INSURANCE BALANCE: I understand and agree that should there be any unpaid insurance balance for sixty (60) days, such balance shall automatically become my responsibility.

MEDICARE ASSIGNMENT: I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I authorize a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

CONSENT TO CARE FOR A MINOR: I hereby authorize Atiyeh Chiropractic to administer care as deemed necessary to: _____

OBLIGATIONS AS TO SERVICES: I hereby acknowledge that I am receiving (or about to receive) health care services at Atiyeh Chiropractic and that I have been advised that Atiyeh Chiropractic is willing to wait for payment for these services so long as there continues to be a likelihood that payment will be made either by my insurance company and/or out of the settlement of my liability case.

I understand and agree that, in the event that:

- A. It is determined that there is no insurance company obligation to pay for Atiyeh Chiropractic's services;
- B. The insurance company for the undersigned refuses to acknowledge an assignment to Atiyeh Chiropractic or to take other actions for the protection of the interest of Atiyeh Chiropractic;
- C. My attorney fails and/or refuses to agree to protect the interest of Atiyeh Chiropractic as determined in its sole discretion; or
- D. I fail to retain an attorney then payment of services at Atiyeh Chiropractic will be made on a current basis and my bill paid in full within thirty (30) days from my last treatment.

COLLECTION: I acknowledge and agree that Atiyeh Chiropractic shall be entitled to reimbursement from me for any legal costs, including attorney fees, for all efforts to collect on any past due account with Atiyeh Chiropractic.

By my signature below, I make the foregoing authorizations, assignments and agreements.

Patient Name (Please Print)

Patient Signature

Date Signed

Witness

Professional Courtesy

By my signature below, I request and authorize Atiyeh Chiropractic to provide my medical doctor with a report for my medical record. Please send to:

Name of Medical Doctor

Office Name

Office Address

() - _____
Telephone

Patient Name (Please Print)

Patient Signature