

ERICKSON CLINIC OF CHIROPRACTIC

I authorize the staff to perform any necessary services needed during diagnosis and treatment. We are required by law to maintain records, therefore X-rays must remain the property of this office.

When you provide us with a wireless telephone number or land line number you are giving us your prior express consent to call that number.

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself - not between my insurance company and this office. I agree to pay my estimated co-payment at the time services are rendered, including any deductibles and further understand that the estimated co-payment is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual co-payment as determined by my insurance company upon processing of my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time (90 days), upon request of this office, I will immediately pay the balance owing on my account.

Due to the contractual agreement of your insurance policy, your insurance company may not have benefits for the following:

- Rehabilitative, maintenance, supportive or Chiropractic Wellness care: (date / visit frequency limitations as defined by the insurance company)
- Services not authorized or limited / minimal services (urinalysis, x-rays, physical therapy, spinal manipulation)
- Certain supplies / services (supports, nutritional supplements, pillows, braces, orthotics)

Assignment of Proceeds, Lien, and Authorization to Disburse Insurance Benefits

I hereby authorize and direct any and all insurance carriers, attorneys, agencies, individuals, ("payers") which may elect or be obligated to pay, provide or distribute benefits to me for any medical conditions, accidents, injuries, or illnesses, past, present, or future to pay directly and exclusively to the ERICKSON CLINIC OF CHIROPRACTIC ("Erickson Clinic" or "Office") such sums as may be owing to Erickson Clinic for charges incurred by me at the Office relating to my condition ("charges"), with such payments to be made exclusively in the name of the Erickson Clinic of Chiropractic. I further grant a lien to Erickson Clinic with respect to my charges. This lien shall apply to all payers and to the full extent permitted by law. For the purposes of this document (herein, "Assignment and Lien"), "benefits" shall include, but not be limited to, proceeds from any settlement, judgment, or verdict, as well as any proceeds relating to commercial health or group insurance, medical payments benefits, personal injury protection, uninsured and underinsured motorist coverage, third-party liability distributions, disability benefits, worker's compensation benefits, and any other benefits or proceeds payable to me for the purposes stated herein.

I authorize this Office to release any information regarding my treatment or pertaining to my case(s) to all payers as defined above to facilitate collection under this Assignment and Lien.

I have read, understood and agree to the above. I agree to be personally and fully responsible for the payment of services rendered by the Erickson Clinic. The information I have provided is true and complete to the best of my knowledge.

Patient Name (please print) _____

Patient Signature _____ Date _____