DIRECT ASSIGNMENT OF BENEFITS & RIGHTS

In consideration of your undertaking to render care, I agree to the following:

1. RELEASE OF INFORMATION: You are authorized to release any information you deem appropriate concerning my physical condition to any Insurance company, attorney, or adjuster To process any claim for reimbursement of charges incurred by me at your treatment facility.
2. RIGHT TO RECEIVE INFORMATION: I authorize my chiropractic provider authority to affix my necessary signature as noted below to obtain medical information from any hospital, medical provider, etc., as It relates to the care being provided by my chiropractic doctor.
3. RIGHT TO RECEIVE PAYMENT: I irrevocably authorize and assign to you, the chiropractic provider, the right to receive direct payment from my attorney or any Insurance company which may become obligated to pay me any sums. The Patient(s) grant(s) to the Provider a Limited Power of Attorney to receive funds, negotiate any drafts or checks and execute any documents related to payment for services rendered to me.
4. ASSIGNMENT OF RIGHT TO SUE: In the event, any insurance company or attorney obligated by contractual agreement to make payment to me for your service charges refuses to make such payment upon demand by you, I irrevocably hereby assign and transfer to you the cause of action that exists in my favor against any such company or attorney and authorize you to prosecute said action either in my name or your name as you otherwise resolve the said claim as you see fit. I understand that whatever amounts you do not collect from said insurance proceeds (whether it be all or part of what is due) shall be paid by me.
5. RIGHT TO LIEN: I also irrevocably assign to you, the chiropractic provider, and grant the right of lien against any and all claims against any third party whose negligence may have caused my Injury, Including their insurance, up to the amount of the bill for treatment, as it relates to my healthcare as provided by you. I also irrevocably instruct my attorney to pay this office in full for services rendered to me for my accident-related injuries from any proceeds or settlements, claims, or judgment regarding said injuries. My legal counsel [**NAME]** or successor or any representative is to pay the doctor/clinic before distributing any proceeds to me. I instruct said legal counsel or representative not to attempt to reduce by means of negotiation my Doctor's bill for services that have been provided to me for the accident/injury/illness, which I have agreed to pay in full.
6. RIGHT FOR INFORMATION: I irrevocably authorize my attorney, [**NAME]** or successor or legal representative, insurer, or any other party regarding my care or case to release financial information about the proposed settlement, settlement/verdict payments, or amounts owed included, but not limited to other providers or legal representatives, liens, billing amounts, and balances. I also instruct all representatives to include all financial information from all facets of my case, including, but not limited to, third-party, uninsured motorists and underinsured motorists.
7. I irrevocably waive the Statute of Limitations regarding my Doctor's right to recover from me directly.
8. I hereby acknowledge that I am receiving (or about to receive) health care services, and I am advised that they are willing to wait for payment for these services, provided 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 (a) 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, payment for services rendered by the above-named Doctor(s) will be made on a current basis and my account paid In full

(continued)

Immediately. In any event, I hereby promise to pay my bill in full within (10) days from the date my liability claim Is settled or after the passage of three (3) months from the date of my last treatment, whichever comes first.

9. If any payment for any services rendered under this agreement becomes delinquent, the patient or patient's guardian shall be responsible for payment of any and all court costs, attorney's fees, service of process fees, and any reasonable additional costs incurred in order to collect or that are associated with collecting monies due on the patient's· account.
10. No Surprise Act: Our fees are derived from the Medical Fees in the United States by the Physicians Medical Information corporation 2022. They have been geographically modified and are billed at the **75th** percentile. A good faith estimated cost for the items and services that would be furnished by this provider or facility plus the cost of any items or services reasonably expected to be provided in conjunction with such items or services will be provided after my first visit. I fully and completely understand that some or all amounts I pay might not count toward my health plan's deductible, out-of-pocket limit, or be covered. I'm giving up some consumer billing protections under federal law. I may get a bill for the full charge for these services or have to pay out-of-network cost-sharing under my health plan. I irrevocably consent in accident cases to have balances applied towards liens or letters of protection with my attorney. With my signature, I acknowledge that I am consenting of my own free will and am not being coerced or pressured.
11. I understand that this document is irrevocable, may not be rescinded, and that my attorney shall not honor any such recession. I hereby instruct that in the event another attorney is substituted in my case, the new attorney honor this lien as inherit to the settlement, judgment, verdict, or any other disposition of any litigation filed or contemplated on my behalf and enforceable upon the case as if it were executed by him/her. I hereby direct my attorney, on-demand, to provide the status of such litigation to the provider or his attorney engaged in any collection efforts. Furthermore, I direct my attorney to contact the provider before disbursement of any funds to ascertain any outstanding balances due and owing.

Dated Signature ___ day of _____ 20 __ Patient

Signature_____

Witness Signature _____

Lawyer's Receipt Verification

- ☐ Sent via Certified US Mail
- ☐ Sent via Fax with Receipt Confirmation
- ☐ Uploaded into www.Mighty.com Records Software and Verified Received

Staff Name [print] _____ Date: _____

Staff Name [sign] _____