Fountain
CHIROPRACTIC CLINIC

Authorization & Assignment

I understand and agree that health and accident policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account by receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will be immediately due and payable. In consideration of your undertaking me, I agree to the following:

1. 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.
2. I authorize the direct payment of any sum from my attorney to you, I now or hereafter owe you out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to you or I based in whole or in part upon the charges made for your services. If my current policy prohibits direct payment to Fountain Chiropractic Clinic, then I hereby instruct the insurance company to make the check out to me as patient and mail it to me as follows:
   Flat Rock: c/o Fountain Chiropractic 24640 Telegraph Rd. Flat Rock, MI 48134
3. In the event any insurance company, obligated by contractual agreement to make payment to me or to you for the charges made for your services, refuses to make such payment upon demanding by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company and authorize you to prosecute said action either in my name as you see fit and further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. I authorize the doctor to make complaints on my behalf to the insurance commissioner for any reason.
4. This authorization and assignment shall be valid and effective for all charges and fees hereafter incurred unless retracted and revoked by me in writing.
5. I understand that on all dates of service that I have presented myself in this office that I have desired treatment for my condition. I understand that my insurance company may rule these treatments to be not “medically necessary” in their opinion and if this happens, I am still responsible for payment.

_____ _____

Signature Date

_____ _____

Witness (Office Use) Date