



Brown Family Chiropractic Center

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The power that made the body heals the body

Assignment, Lien and Authorization Insurance Benefits

To Whom It May Concern:

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage and hereby assign and convey directly to BROWN FAMILY CHIROPRACTIC CENTER, P.A. all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any/all plan documents, insurance policy and or settlement information upon written request from such doctor or clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and or employee health care plan any claim, choice in action, or other right I may have to such insurance and or employee health care benefits coverage under any applicable insurance policies and or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, choice in action or right against my insurers and or employee health care plan, including, if necessary, bringing suit with such doctor and clinic against such insurers and or employee health care plan in my name but at such doctor or clinic's expense.

Should this assignment be prohibited in part or in whole under any anti-assignment provision of my policy/plan, please advise and disclose to my provider in writing such anti-assignment provision within 30 days upon receipt of my assignment, otherwise this assignment should be reasonably expected to be effective and such anti-assignment is waived.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____