

# Authorization and Assignment

## Consent for treatment

I the undersigned, a patient in this office, hereby authorize Sean Reese, D.C. (and whomever he may designate as his assistant(s)) to administer treatment as is necessary.

I also certify that no guarantees or assurances have been made to me as to the results that may be obtained.

I understand and agree that health or accident insurance policies are an agreement between the insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making any collection from any insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

## This lets the insurance company or attorney pay your bill with any insurance or award proceeds

The undersigned hereby assigns to Sea Coast Chiropractic all rights, title, and interest in and to any compensation or payment in any form that the undersigned received or shall receive as a result of or arising out of the injuries sustained by the patient. The undersigned hereby authorizes and directs any person or corporation having notice of this assignment to pay to Sea Coast Chiropractic directly the amount of the indebtedness owed to Sea Coast Chiropractic in connection with services rendered to the patient.

## This says that you are ultimately responsible for your bill.

I understand that I remain personally responsible for the total amounts due on my account(s) with Sea Coast Chiropractic. Signing this form does not require that Sea Coast Chiropractic could not collect payments at the time services are rendered, at their option. If asked, I agree to make payments on my account.

## This says that we can release information about you/your health to help get the bill paid.

I authorize Sea Coast Chiropractic to release any information, pertinent to my case, to any insurance company, adjuster, Attorney to facilitate collection under this Assignment, Lien, and Authorization.

## This lets us sign checks sent to us as a payment on your bill here.

I agree that Sea Coast Chiropractic may endorse, sign my name to any checks sent to the clinic as payment on my account(s).

## This alerts you that you will be charged if the account is sent to collection.

If this account is turned over to an attorney or agency for collections, I understand and agree that I will be liable for all expenses incident to the collection of my balance, including attorney fees.

Date: \_\_\_\_\_

Signed: \_\_\_\_\_ Print: \_\_\_\_\_