

Greer Chiropractic Center, PA - Karen Waters Thomas, DC
215 W Poinsett St - Greer, SC 29650
864-877-5795

ASSIGNMENT, LIEN AND AUTHORIZATION INSURANCE BENEFITS AND ATTORNEY

Whom it may concern: I, _____ hereby authorize and direct you, my insurance company, and/or my attorney,
to pay directly to:

GREER CHIROPRACTIC CENTER, PA
215 W. Poinsett St. Greer SC 29650 Tax ID: 57-0956580

such sums as may be due and owing this Office for services rendered me, both by reason of accident or illness, and by reason of any other bills that are due this office, and to withhold such sums from any disability benefits, medical payments benefits, No-Fault benefits, health and accident benefits, workmen's compensation benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgement or verdict on my behalf as may be necessary to adequately protect said Office. I hereby further give a lien to said Office against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgement or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by said Office. This is to act as an assignment of my rights and benefits to the extent of the Office's services provided.

- In the event my insurance company obligated to make payments to me upon the charges made by this Office for their services refuses to make such payments, upon demand by me or this Office, I hereby assign and transfer to this Office any and all causes of action that I might have or that might exist in my favor against such company and authorize this Office to prosecute said cause of action either in my name or in the Office's name and further I authorize this Office to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

- I understand that I remain personally responsible for the total amounts due the Office for their services. I further understand and agree that this Assignment, Lien or Authorization does not constitute any consideration for the Office to await payments and they may demand payments from me immediately upon rendering services at the option.

- I authorize the Office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment, Lien and Authorization, Lien and Authorization. I agree that the above mentioned Office be given power of Attorney to endorse/sign my name on any and all checks for payment of my doctor bill.

- I further understand that if payment is made to me, the total is due to GREER CHIROPRACTIC CENTER, PA no later than 30 calendar days after payment is issued from the insurance company. If not, this is considered breach of trust and punishable in a court of law. _____

Certification: I certify that: I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving health care; I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service; I agree the provider's prices for medical services, treatment and supplies are reasonable and customary.

Caution: Please read before signing. If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the above.

Patient's Signature

(Please Print)

(If patient is a minor, signature of parent/guardian)