Family Chiropractic of Charleston

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IRREVOCABLE
ASSIGNMENT, LIEN AND AUTHORIZATION
INSURANCE BENEFITS AND ATTORNEY

To Whom It may Concern:

I hereby authorize and direct you, my insurance company, to pay directly to Dr. Brian P. Lima 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 to this office, and withhold such sums from any disability benefits, medical payment benefits, no-fault benefits, health and accident benefits, Workers' compensation benefits, or any other insurance benefits obligated to reimburse me from any settlement, judgment 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, judgment 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 cause 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 comprise, settle or otherwise resolve such claim of cause of action as they see fit.

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

I authorize the Office to release any information pertinent to my case to any insurance company, adjustor or attorney to facilitate collection under this assignment, 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 and agree, that if this Office must take any action to collect an outstanding balance on my account, I will be responsible for payment of and will reimburse this Office for all costs of such collection efforts, including but not limited to all court costs and all attorney fees.

Signed_____

Date _____