CHIROPRACTIC HEALTH & WELLNESS
DR. ADAMS, D.C.
1615 PRECINCT LINE RD STE #104
HURST, TEXAS 76054

Assignment of Benefits

The undersigned patient and or responsible party in addition to continuing personal responsibility, and in consideration of treatment or to be rendered assigns to the physician of facility named above the following rights and power and authority.

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney, or insurance adjuster, for the purpose of processing my claim for benefits and payment of service rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the term of the policy, including the exclusive, irrevocable tight to receive payment for such service, make demand in my name for payment, and prosecute and receive penalties, interest, court cost, or other legally compensable amounts owned by an insurance company, in accordance with **Article 21.55** of the Texas Insurance code or other applicable insurance or state stature. I, as the patient and/or responsible party, further agree to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/ us for treatment rendered by the physician/facility an named above, you are hereby tendered demand to pay in full the bill for services rendered by the physician named above **within 60 days following** your receipt of such bills are payable under the terms of my/ our policy for benefits, less any amount which I/we personally owe which are not payable under the terms of the policy. This demand specifically conforms to **Article 21.55** of the Texas Insurance Code, probing for attorney fees, **18% penalty**, court cost, an interest from judgment, upon violation.

THIRD PARTY LIBILITY: If my injuries are the result of negligence from a third party, then I instruct the liability carrier to cut a separate draft to payable directly to the physician/ facility named above.

STATUE OF LIMITATIONS: I waive my rights to claim any Statue of Limitations regarding claims for services rendered or to be rendered by the physician/ facility name above in addition to reasonable costs of collection, including attorney fees and court costs if incurred.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician/ facility named above the power to endorse my named upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and health care rendered by the physician/ facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/ our account or forwarded to my/ our adder upon request in writing to the physician/ facility named above.

TERMINATION OF CARE WAIVER: I hereby acknowledge and understand that if I so not keep appointments as recommended to me by my caring doctor at the chiropractic clinic, he/ she has full and complete right to terminate responsibility for my care and relinquish any disability granted to me within a reasonable period of time. If, during the course of my care, my insurance company requires me to take examination from any other doctor, I will notify this physician/ facility immediately. I understand that failure to do so may jeopardize my case.

A PHOTOCOPY OF THIS INSTRUMENT SHALL SERVE AND ORIGINAL

Signature of Patients and/ or responsible parties:

____ Date: ____________________
Signature

____ Date: ____________________
Witness