Lakewood Chiropractic
2222 University Blvd West
Jacksonville, FL 32217
Ph: 904-733-7020, Fax: 904-733-0119

POWER OF ATTORNEY AND MEDICAL RELEASE

POWER OF ATTORNEY TO ENDORSE CHECKS AND/OR TO SIGN ANY PIECE OF PAPER WHICH WILL ENHANCE OR EXPEDITE PAYMENT TO PROVIDER FOR SERVICES RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS and ASSIGNMENT OF BENEFITS/AUTHORIZATION TO PAY.

Know by all these present that: The undersigned has made, constituted and appointed, and by these present does hereby make constitute and appoint LAKEWOOD CHIROPRACTIC, and any of its duly authorized agents and employees as and to be the undersigned's true and lawful attorney for and in the undersigned's name, place and steed to endorse any and all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and the said LAKEWOOD CHIROPRACTIC, which checks, drafts or money orders are made payable for services which have been made by LAKEWOOD CHIROPRACTIC, at the request or with the knowledge and approval of the undersigned and/or the maker of check, draft of money order.

Furthermore, the undersigned allows LAKEWOOD CHIROPRACTIC or any of its agents to sign any papers that will be necessary to enhance, expedite and/or allow payment to said provider. This may include affidavits of non-ownership of vehicles, insurance forms, and other statements.

The undersigned by these present does give and grant said LAKEWOOD CHIROPRACTIC as attorney the full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and cashing of said checks are concerned as well as any other documents.

MEDICAL RELEASE

A photocopy of this document shall be sufficient to authorized any person having records of medical treatment, services, or supplies pertaining to me to release true copies of same to LAKEWOOD CHIROPRACTIC or any insurer providing coverage to me in connection with the processing of any claim for benefits made by me or by the assignee herein. A photocopy of this document shall be as findings as an original signature page.

The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do or cause to be done by virtue of the present.

ASSIGNMENT OF BENEFITS

I, _____, Hereby authorize_____
(Name of Insured/Patient) (Name of Insurance Carrier)
to make medical benefits payments otherwise payable to me for services rendered by LAKEWOOD CHIROPRACTIC, but not to exceed the charges of those services, payable to and mailed directly to

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Furthermore, I hereby IRREVOCABLY ASSIGN to LAKEWOOD CHIROPRACTIC the rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statues for any service and or charges provided by LAKEWOOD CHIROPRACTIC. I hereby instruct the insurance carrier that in the event the subject medical benefits are disputed for any reason, including medical reasonableness and/or necessity, that the amount of unpaid benefits claimed by LAKEWOOD CHIROPRACTIC is to be set aside and not disbursed until the dispute is resolved.

In Witness whereof the undersigned have hereunto set their hands, this _____day of_____.

_____ _____
PATIENT'S SIGNATURE PATIENT'S NAME (Print Please)

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