PREFERRED CHIROPRACTIC CENTER
AUTHORIZATION & ASSIGNMENT FORM

In consideration of your undertaking to treat me, I agree to the following:

You are hereby authorized to release any information you deem appropriate concerning my case to any insurance company, attorney, court or adjuster in order to process any claim for reimbursement of charges incurred for service rendered me by you.

<u>Personal injury /Auto medical payment</u>: Let my signature on the bottom of this page indicate that I authorize any court, attorney, insurance company or adjuster involved with my case to disperse funds from my settlement to Preferred Chiropractic Center first. Additionally, I agree not to personally withdraw any money from my settlement check until Preferred Chiropractic Center is paid in full. In the event that I am not offered a settlement, I personally guarantee payment for all services I have received at Preferred Chiropractic Center. I understand that Chiropractic adjustments are $75.00 per treatment, X-rays are $50.00 each, Exams are $150.00 - $250.00 each and Therapies are $35.00 - $50.00 each. I / my representative (s) agree not to ask Preferred Chiropractic Center to reduce its fees under any circumstances.

<u>General</u>: I understand that I am responsible for knowing what my health insurance policy does and does not cover. I realize that verification of my insurance benefits is a courtesy provided by Preferred Chiropractic Center in order to save me time. However, I agree not to hold Preferred Chiropractic Center or Stephen G. Prefer DC financially responsible in the event that inaccurate benefits information is ever provided by my health insurance carrier. I understand that Stephen G. Prefer DC is a participating provider for Aetna, United Healthcare and Medicare insurance companies only at this time. I acknowledge and agree that ultimately this is a contract between Preferred Chiropractic Center and myself and that I am responsible for payment.

I understand that payment for Chiropractic services rendered me by you is due on the date of service. I realize that my health insurance benefits can't be verified after normal business hours, weekends or holidays. I am financially prepared to pay today for all Chiropractic services I receive at Preferred Chiropractic Center.

I authorize Stephen G. Prefer DC to turn my account over to a collection agency if my entire bill at Preferred Chiropractic Center is not paid within 30 days of my last treatment date. I fully understand that if my account should have to be turned over to a collection agency, it will be solely my responsibility to pay all collection agency fees "in addition to" my outstanding bill at Preferred Chiropractic Center. In the event that I fail to fully comply financially, I authorize Stephen G. Prefer DC to release the following information to a collection agency: my name, home and work addresses, social security number, phone numbers, billing history and treatment recognition signatures. Lastly, should a legal situation arise and judgment is awarded to Preferred Chiropractic Center, I agree to personally guarantee payment for all fees involving: court, attorneys, garnishments, process servers, Sherriff's fees and mailings. I realize that these professional fees are an <u>additional expense</u> that I have incurred and I understand that these expenses will be added to my balance at Preferred Chiropractic Center.

Patient Signature: ____ Date ____________

Print Name: ____