

# AUTHORIZATION AND ASSIGNMENT

To Ruddell Chiropractic Clinic

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

## Authorization to Release Information

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process claims for reimbursement of charges incurred by me for professional services rendered by you, and I hereby release you of any consequence thereof.

## Assignment of Cause of Action

In the event any insurance company is obligated by contractual agreement to make payment to me or to you for the demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is/are believed to be correctly set forth under pertinent data below) and authorize you to prosecute said action either in my name or your name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim.

## Authorization to Pay Directly to Doctor

To \_\_\_\_\_

(Insurance company/attorney/other party)

In consideration of the chiropractic services rendered (or to be rendered), I authorize and direct payments to Ruddell Chiropractic Clinic by any insurance company obligated to reimburse me for services/charges or my attorney out of the proceeds of any settlement of my case or any other party obligated to make payment to me for any sum I now or hereafter owe.

## Acknowledgment and Understanding

I hereby acknowledge that I am receiving (or about to receive) treatment at the Ruddell Chiropractic Clinic and that I have been advised that the doctor(s) providing the services is/are willing to wait for payment for these services, provided that there continues to be a reasonable chance that payment will be made by insurance proceeds or out of the settlement of a liability claim.

I also understand that if it is determined: (a) That there is no insurance company obligated to pay for the services or if the insurance company refuses to acknowledge payment to the doctor(s) (b) If a liability claim exists and my attorney refuses to protect the interest of the doctor(s) (c) No settlement has been reached with the insurance company/attorney/other parties involved within passage of three months from my last treatment, then payment for services rendered at the Ruddell Chiropractic Clinic will be made until my bill paid in full.

Dated \_\_\_\_\_

\_\_\_\_\_  
(Patient Signature)

\*Copy to patient.

\_\_\_\_\_  
(Witness)