Brewer Chiropractic Clinic
702 W Interstate 20, Suite 100
Arlington, TX 76017
(817) 467-2010

Authorization and Assignment

To: Brewer 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 any claim for reimbursement of charges incurred by me, as a result of 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 efforts have been made to collect the sums due from the insurance company (or companies) contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due), I personally owe you, and agree to pay in a current manner.

Authorization to pay Directly to Doctor

TO: _____
(Name of attorney and/or insurance company)

In consideration of the chiropractic services rendered and to be rendered by him, I authorize and direct the payment to Brewer Chiropractic Clinic any sum I now or hereafter owe him by you, my attorney, out of the proceeds of any settlement of my case, and/or by any insurance company obligated to reimburse me for the charges for his services or otherwise obligated to reimburse me for the charges for his services or otherwise obligated to make payment to me or him based in whole or in part upon the charges made for his services. If my current policy prohibits direct payment to the doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

Acknowledgment and Understanding
c/o Brewer Chiropractic Clinic
702 IH-20 West, Ste. 100
Arlington, TX 76017

I hereby acknowledge that I am receiving (or about to receive) health care services at the Brewer Chiropractic Clinic, and that I have been advised that the doctor providing the services is willing to wait for payment for these services, provided that there continues to be a reasonable chance that payment will be made either by insurance proceeds or out of the settlement of a liability claim. I understand that if it is determined either:

- That there is no insurance company obligated to pay for the services, or if the insurance company involved refuses to acknowledge an assignment to the doctor or make other provisions for the protection of the interest of the doctor; or
- If a liability claim exists, and my attorney refuses to agree to protect the interest of the doctor, or if I have not engaged the services of an attorney;

Then payment for services rendered by Brewer Chiropractic Clinic will be made on a current basis and bill paid in full as soon as my liability claim is settled or the passage of three months from my last treatment, whichever occurs first.

Dated the _____ day of _____, 2014.

_____ _____
Patient's Signature Witness