



PERFORMANCE & HEALING CHIROPRACTIC

124 South Fairfield, Suite B

Layton, UT 84041

Tel (801) 774-0266

Fax (801) 774-9650

AUTHORIZATION & ASSIGNMENT OF BENEFITS

Patient Name: _____ Date: _____

Name of Insurance for Current Year: _____ New Same

Deductible: _____ January to January, Other _____ Limits _____

1. You are to release any information you deem appropriate concerning my health condition to any insurance company, attorney, or adjuster in order to process any claim for charges incurred by me, so that the doctor and/or clinic will be directly reimbursed.
2. I authorized and assign the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obliged to reimburse me for the charges for your services or otherwise obligated to make payment to me or you in whole or in part upon the charges made for your services.
3. I give assignment and lien against any claims against a third party whose negligence may caused my injury or illness, up to the amount of the bill for treatment.
4. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exist in my favor against any such company, 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 as you see fit. 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.
5. I waive the statue of limitations regarding my doctor's right to recover.

I hereby instruct and direct the insurance company to pay by check made out and named directly to:

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Or

If my current policy prohibits direct payment to doctor, then I hereby also instruct
and direct you make out the check to me and mail it as follows:

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I assign the professional or medical expense allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHT AND BENEFIT UNDER THIS POLICY.** This payment will not exceed indebtedness to the above mentioned assignee, and I have agree to pay, in a current manner, or any balance of said professional service charges over and above this insurance payment.

This assignment will remain effective until revoked by me in writing. A photocopy of this Assignment shall be considered as effective and valid as the original.

Signed: _____ Date: _____

Witness: _____