PATIENTS OR AUTHORIZED PERSONS SIGNATURE

I authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or the party who accepts assignment.

_____

DATE SIGNATURE

I authorize payment of any medical benefits from me to be paid directly to Mattar Chiropractic Clinic, for any services rendered to me.

_____

DATE SIGNATURE

AUTHORIZATION AND ASSIGNMENT

In Consideration of your undertaking to care for me, I agree to the following:

1) 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.
2) I authorize the direct payment to you of any sum I now or here after owe you by my attorney out of proceeds of any settlement of my case and by any insurance company obligated to make payment to me or to you based in whole or in part upon the charges made for you services.
3) In the event any insurance company obligated by contractual agreement to make such 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 transfer to you the cause of action that exists in my favor against any such company and authorize you to prosecute said action in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However it is from the insurance 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 companies, whether it be all or part of what is due. I personally owe you.
4) In addition to the above, I hereby waive the statue of limitations on collection and/or recovery in the state, Michigan.
5) I further agree that this authorization irrevocable until all monies owed, are paid in full.

_____

DATE SIGNATURE