



750 E. Interstate 30, Suite 130, Rockwall, TX 75087, 972 772 2722, fax 972 722 1234

ASSIGNMENT OF BENEFITS

The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered, assigns to the physician or facility named above the following rights, power and authority:

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney, or insurance adjuster, for purposes of processing my claim for benefits and payment of services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, court costs, or other legally compensable amounts by any insurance company, in accordance with **article 21.55** of the Texas Insurance Code or other applicable insurance or state statute. I, as the patient and/or responsible party, further agree to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above, you are hereby tendered demand to pay in full the bill for services rendered by the physician/facility named above within 21/45 days (electronic/paper) following your receipt of such bill for services to the extent such bills are payable under the terms of demand specifically conforms with **Article 21.55** of the Texas Insurance Code, providing for attorney fees, **18% penalty**, court costs, and interest from judgment, upon violation.

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the liability carrier to cut a separate draft to pay in full for all services rendered, payable directly to the physician/facility named above.

STATUE OF LIMITATIONS: I waive my rights to claim and Statute of Limitations regarding claims for services rendered, or to be rendered, by the physician/facility named above, in addition to reasonable costs of collection, including attorney fees and court costs if incurred.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician/facility named above the power to endorse my name upon any checks, drafts, or other negotiable instruments representing payment from any insurance company representing payment for treatment and health care rendered by physician/facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our office upon request in writing to the physician/facility named above.

TERMINATION OF CARE WAIVER: I hereby acknowledge and understand that if do not keep appointments as recommended to me by my caring doctor at this chiropractic clinic, he/she has the full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. If, during the course of my care, any insurance company requires me to take an examination from any other doctor, I will notify this physician/facility immediately. I understand that failure to do so may jeopardize my case.

A photo copy of this instrument shall serve as original.

Signature of Patient and/or responsible parties:

1. _____

Date _____

2. _____

Date _____