Millcreek Chiropractic 5526 So Van Winkle Expressway, Murray, UT 84117 (801) 747-2447 (p) (801) 716-3532 (f)

AUTHORIZATION and ASSIGNMENT

The undersigned patient and/or responsible party, in addition to continuing personal responsibility and in consideration of treatment rendered or to be rendered, assign to Millcreek Chiropractic, LLC, including all doctors, staff and service providers hereafter known collectively as “Facility”, the following rights, power, and authority:

RELEASED INFORMATION: You are authorized to release and permit the examination or copying of any of my medical records, x-rays, laboratory reports, and the results of all tests of any type or character as needed for treatment, payment, and health care operations.

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 benefits to the extent of your bill for total services if such benefits are owed within 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, interest, court costs, and other legally compensable amounts owed by an insurance company. 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. The Facility is also assigned the exclusive, irrevocable right to request and receive from any insurance company or health care plan any and all information, PIP ledger and documents pertaining to my policies including a copy of such policy, and any information or supporting documentation concerning or touching upon the handling, calculation, processing, or payment of any claim.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the Facility as named above, you are hereby tendered demand to pay in full the bill for services rendered by the Facility named above following your receipt of such bill for services to the extent such bills are payable under the terms of my/our policy for benefits, less any amounts which I/we owe personally which are not payable under the terms of your policy. We reserve the right to demand and receive payment in full at our discretion at any time.

THIRD PARTY LIABILITY: If patient(s) treatment(s) for injuries are the result of the negligence of any third party, then patient(s) grant a lien against any recovery from such third party(s) to the extent of the bills for treatment in favor of the Facility named above. I also grant authority to demand such liable third parties to make payment for my/our claims to the Facility named above for any and all payable claims for such injuries.

STATUTE OF LIMITATIONS: Patient(s) waive the right to claim any Statute of Limitations regarding claims for services rendered or to be rendered by the Facility named above, in addition to reasonable costs of collection including attorney fees and court costs, if incurred. I also agree to pay a minimum finance charge of 1.5% per month (annual percentage rate of 18%) or a minimum of $20.00 whichever is more on any amount not paid after 30 days. If collection is made by suit or otherwise, patient and/or responsible party agree to pay interest until paid, collection costs of up to 50% of the remaining balance, plus all attorney fees and court costs.

LIMITED POWER OF ATTORNEY: I hereby grant to the Facility named above the power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and health care rendered by the Facility. 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 address upon request in writing to the Facility named above. In the event that any provision of this Agreement is determined to be invalid or unenforceable, all other provisions of this Agreement shall remain enforceable.

A PHOTOCOPY OF THIS INSTRUMENT SHALL SERVE AS ORIGINAL

Signatures of Patient(s) and Responsible Party:

1. _____ Date: _____ Relationship to Insured: _____

2. _____ Date: _____ Relationship to Insured: _____