NOTICE OF DOCTOR'S LIEN

TO:_____

RE: Patient:_____

Claim Number:_____

Date of Accident:_____

I do hereby authorize Family Chiropractic Centers at 1100 Carthage Street Sanford, NC 27330, to furnish you with my medical records including examination reports, radiographic reports, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you to pay directly to said doctor such sums as may be due the owing him for medical services rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from my settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor. I hereby further give a lien on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney or myself, as the result of the injuries for which I have been treated in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration for his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may be eventually recover said fee.

I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this accident and I instruct my attorney or insurance to do the same and promptly deliver a copy of this lien to any substituted or added attorney(s)

I have been advised that if the insurance company does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due and payable.I further direct the insurance company to pay said doctor one hundred percent of all chiropractic cost associated with my treatment. I understand all costs associated with my care and believe them to be necessary, reasonable and customary.

Please acknowledge this letter by signing below and returning to the doctor's office.

Patient's Signature_____Date:_____

The undersigned acknowledges receipt of this lien.

Date:_____ Authorized Signature_____

Please fax copy to our office at (919) 776-4032 for confirmation of receipt. Thank you

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RE: Patient:_____

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Please fax copy to our office at (919) 776-4032 for confirmation of receipt. Thank you

Family Chiropractic Center of Sanford

1100 Carthage Street
Sanford, North Carolina 2 7 3 3 0
(919) 775-2114 (919) 776-4032

To All Personal Injury Patients

We will file all insurance associated with this accident; however we must have the accurate information to do so. If we do not have the accurate information, you will be responsible to pay for services at the time they are rendered. You must provide us with all insurances you wish to file within 2 days of your initial treatment or there will be a $5.00 charge for any additional claims.

Please provide us with the following information for each insurance company:

INSURANCE # 1:
Name of insurance co.:_____

Address of insurance co.:_____

_____

Phone # of insurance co.:_____

Claim or Policy #:_____

Adjustor's Name:_____

INSURANCE # 2
Name of insurance co.:_____

Address of insurance co.:_____

_____

Phone # of insurance co.:_____

Claim or Policy #:_____

Adjustor's Name:_____

I have read and understand the above statement. I understand that I am responsible for any charges incurred at Family Chiropractic Center of Sanford. I further understand that all insurance payments will be sent to Family Chiropractic Center of Sanford, including Med Pay, and in the case of any overpayment, a refund will be issued upon settlement of my case.

Signature_____Date _____

Witness_____

Authorization and Assignment

To: Family Chiropractic Center of Sanford, P. A.
1100 Carthage Street, Sanford, North Carolina 27330

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 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 further authorize you to compromise, settle of otherwise resolve said claim as you see fit. However, it is understood that until all reasonable 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 the doctor named above of 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 of in part upon the charges made for his services .

Acknowledgement and Understanding

I hereby acknowledge that I am receiving (or about to receive) health care services at the Family Chiropractic Center of Sanford office, and that I have been advised that the doctor(s) providing the services is/ are willing to wait for payment for these services, provided that these services, provided that there continues to be b 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:

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

Then payment for services rendered by the doctor(s) at the Family Chiropractic Center of Sanford office will be made on a current basis and *my* bill paid in full as soon as my liability claim is settled or the passage of three months from my last treatment, whichever comes first.

_____ _____
Patient's Name Date of Birth

_____ _____
Patient's Signature Date

_____ _____
Witness Date

Authorization and Assignment

To: Dr. Skip Austin, D. C.

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 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 further authorize you to compromise, settle of otherwise resolve said claim as you see fit. However, it is understood that until all reasonable 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 the doctor named above of 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 of in part upon the charges made for his services.

Acknowledgement and Understanding

I hereby acknowledge that I am receiving (or about to receive) health care services at the Family Chiropractic Center of Sanford office, and that I have been advised that the doctor(s) providing the services is/ are willing to wait for payment for these services, provided that these services, provided that there continues to be b 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:

(1) That there is no insurance company obligated to pay for the services. of if the insurance company involved refuses to acknowledge an assignment to the doctor(s) or make other provisions for the protection of the interest of the doctor(s) ; or

(2) If a liability claim exists, or my attorney refuses to agree to protect the interest of the doctor(s), or if I have not engaged the services of an attorney;

Then payment for services rendered by the doctor(s) at the Family Chiropractic Center of Sanford office will be made on a current basis and my bill paid in full as soon as my liability claim is settled or the passage of three months from my last treatment, whichever comes first.

Patient's Name _____ Date of Birth _____

Patient's Signature _____ Date _____

Witness _____

ATTENTION PERSONAL INJURY PATIENTS

As a courtesy to our patients who have been involved in an accident and have retained an attorney, we will wait for payment until the attorney has made a settlement.

All financial agreements are between Family Chiropractic Center of Sanford and you the patient and not with Family Chiropractic Center of Sanford and the attorney which means the patient has overall responsibility for all charges incurred with Family Chiropractic Center of Sanford.

If upon settlement by the attorney, the full bill is not paid, the patient is responsible for the remaining charges plus any interest charges. The patient will also be responsible for any fees acquired as a result of any collections actions deemed necessary.

By Family Chiropractic Center of Sanford agreeing to wait for payment, you as the patient must ensure that your attorney makes payment for all charges incurred.

I understand the above statement and agree that I am responsible for all charges incurred with Family Chiropractic Center of Sanford. I understand that Family Chiropractic Center of Sanford has agreed to wait for payment until my case is settled and I in turn agree to protect the interest of Family Chiropractic Center of Sanford.

Patient Name (Printed)_____

Patient Date of Birth _____

Patient Signature_____

Guardian Signature_____

Date_____