concept | CHIROPRACTIC + REHAB

AUTHORIZATION AND ASSIGNMENT

PIP INFORMATION - Attorney fills out this box		
If available please provide PIP info for your client		
Car Insurance (PIP) carrier name:		
Claim #:	Adjustor's Name:	Phone #:

AUTHORIZATION AND ASSIGNMENT

Patient (or legal guardian) fills out this section

I, _____*(please print name clearly)* hereby authorize Concept Chiropractic and Rehab and any of its affiliate companies to furnish, upon request, to my attorney, _____ *(please print Attorney's name)* whose signature appears below, copies of medical copies of medical reports of examination, diagnoses, treatment, prognosis, etc. pertaining, but not necessarily limited to my condition resulting from injuries sustained on _____ *(date of accident)*. I hereby irrevocably authorize and direct said attorney receiving such medical reports to pay my physician's charge for services rendered by them, or any balance thereof, which shall include their charge for attendance in court, if required as an expert witness whether they testify or not, and for reports made of depositions given in this matter. Unless the Concept Chiropractic and Rehab doctor is instructed otherwise, they will assume that a narrative report is expected upon my release from their care. Said payment is to be made from any monies received by said attorney as a result of compromise or by way of collection of a judgment on my claim for injuries sustained on the above date. Payment of this amount as herein directed shall be the same as if paid by me. This authorization to pay my physician shall constitute and be deemed as assignment of so much of recovery as shall cover the aforesaid bill. I am also authorizing my PIP to be mailed and paid directly to my physician Concept Chiropractic and Rehab. I also authorize Concept Chiropractic and Rehab to file for and collect their fees through either my health insurance and/or Personal Injury Protection Insurance if and when available. In the event my Personal Injury Protection coverage is paid directly to me, I agree to pay Concept Chiropractic and Rehab immediately from these proceeds, with this bill taking precedence over any other financial demands which may have arisen as a result of this accident. I understand that payment to my physician for professional services is not to be delayed during the pendency of my claim. In the event of any dispute as to the charge for services rendered, I hereby authorize and direct my attorney to withhold the full sum claimed by my physician until such time as the matter is settled by compromise or judgment. It is agreed that nothing herein relieves me of the primary responsibility and obligation of paying my physician for the services rendered, and that payment by me for said medical services is not contingent upon any settlement, judgment, or verdict by which I may eventually recover said fee. In the event that my claim has not been settled within 180 days of my release from Concept Chiropractic and Rehab, I agree to pay any remaining balance due on my account in full at that time.

_____ _____

Signature Date

_____ _____

Witness Date

ATTORNEY FILLS OUT THIS SECTION

I, _____, accept the above assignment and agree to observe the terms set forth, and to withhold such sums from my settlement, judgment, or verdict as may be necessary to adequately protect Concept Chiropractic and Rehab interest.

_____ _____

Attorney's Signature Date