ASSIGNMENT & AUTHORIZATION

I specifically authorize that this assignment may be paid to Dr. Mark J. Stubbendieck D.C. from disability benefits, medical payments, or from ANY benefits due me under this claim. I understand and agree that any unpaid balances not covered by this policy will be paid by me.

I also authorize Dr. Mark J. Stubbendieck (D.C.) to release any information, pertinent to my case, to any insurance company, Adjuster, or attorney involved in the case.

Dated at____ this _______________, __________
City & State Date

____ ___________________________
Signature of Patient Witness

FINANCIAL RESPONSIBILITY – I agree to be financially responsible for all charges incurred at this clinic, including my insurance deductible, co-payment and any services rejected by my insurance company.

____ ____________________________
Signature of Patient Date

I hereby state and agree that a photocopy of this document will be deemed as valid and binding on all parties as the original copy.

Credit Guarantee for Auto Insurance Assignment
Personal Balances

Insurance Assignment

Our Auto Insurance Assignment Program is designed to render you immediate care and keep your out-of-pocket expenses to a minimum. As a courtesy to you, we bill your insurance carrier on your behalf and wait up to 6 months for payment. Please remember, however, that you are ultimately responsible for payment. As a prerequisite, we ask that you provide a credit card to guarantee payment of your bill and that you provide us with the following:

Complete Automobile Insurance Information: ____
Your Family Health Insurance Plan Information: ____

Filing Procedure
We will periodically submit claims on your behalf to both your automobile and health insurance carriers.

Any overpayments resulting in credit balances will be refunded promptly at the conclusion of your care.

Balances not paid within 6 months after conclusion of your care will be charged to your designated credit card below. You will be sent a payment voucher. Should settlement be reached prior to the 6 month grace period or should care be terminated for any reason prior to your physician dismissal all balances become immediately, will be charged to your credit card and are subject to monthly interest charges.

CREDIT CARD (mark with an X): AMEX___ VISA___ MC___ DISCOVER____
CARDHOLDER NAME____
CARD#____ EXP. DATE________________________

I agree to the above terms and authorize you to bill the charge. I understand that should payment not be received within 6 months after termination of my care or should I terminate care before being dismissed by your physician, I will be responsible for any remaining balance and charged the outstanding amount.

Signature of Patient____ **Date**_________________________________