old mill chiropractic
Whole Body & Family Wellness

Phone: (803) 808-0711
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Accident & Injury Assignment – Authorization of Lien

Name: _____ Date: _____

I, the assignee, being the patient or legal guardian for said minor listed below, do hereby irremovable authorize, direct, assign and give a full lien to the office named above hereinafter referred to as the "facility" against any & all Insurance benefits, proceeds of any settlement, judgment or verdict which may be paid to the undersigned as a result of the injuries or illness for which I have been treated by the facility. I, the assignee, further authorize any and all insurance companies, case managers, attorneys & any and all third party payers to pay directly to the facility all sums of money due to them for any & all services rendered to me or minor by whom I am responsible for by reason of accident, injury, illness and by any & all reason of any other bills that are due or may become due, and to withhold such sums from any health & accident, workers compensation and or including all insurance or third party benefits. Assignee agrees that this facility & staff may process medical reports, deliver medical records, consultations, depositions and/or court appearances which must be paid in full in advance by me, and authorizes this facility to release any information pertinent to said health care to any insurance company, adjuster, attorney or legal service bureau to facilitate collections under the terms of this document. Assignee grants the facility a full power of attorney to endorse and/or sign my name on any & all checks for payment of any indebtedness owed this office and assignee.

Informed Consent

I understand that this facility, its doctors & staff are accepting my case based on examination findings and believe the outlined treatment should reduce change and/or improvement. However as with any diagnostic test, procedure, examination or doctors care a guarantee of improvement or complete recovery cannot be made and it is even possible that no change will occur, or I may get worse. I further understand that in the practice of medicine, chiropractic, psychological counseling & physical therapy there are some risks including but not limited to fractures, disk injuries, strokes, dislocation, sprains-strains, drug interactions & reactions, including cardio-pulmonary arrest, death and/or other injuries or side effects which cannot be pre-determined. I do not expect the doctor/provider to be able to anticipate and explain all risks and/or complications, and I wish to rely on the doctor/provider to exercise judgment during the course of the procedure(s) which the doctor/provider feels at the time is in my best interest. Therefore, I give my full consent to the doctor/provider to render treatment on me or the minor for whom I am legally responsible by a health care provider of this facility.

Insurance Benefits – Payment Terms & Conditions

1. As a courtesy, the facility will obtain a verification of applicable insurance benefits as they are quoted to us but some third party payers mis-quote benefits, coverage and liability. Our facility & staff are not responsible for what a third party payer and/or representative may tell us. Any insurance contractual obligations or arrangements between you and an attorney or third party payer are between you and your insurance carrier and/or the third party payer.

2. Our facility will file initial insurance claims for you. Secondary claim submission and/or additional reports or documents sent for your benefit may result in an additional filing medical report charge which you are responsible to pay.

3. Co-pays, deductibles and all non-covered service charges are the day and prior to the time service is rendered.

4. All account balances, including automobile and work injury claims must be paid in full within 60 days of treatment. Patients and/or legal guardians are fully responsible for all money owed this office and such payment is not contingent on any settlement, claim, judgment, or verdict by which they may eventually recover said fee and it is also regardless or any attorney liens or pending settlement(s). If a third party payer fails to pay said balance in full within the 60-day period, the patient must pay the balance in full. Assignee is fully responsible for all money owed this facility for any and all treatment, products & services rendered to the patient or minor shown below.

5. A service charge is computed by a 'periodic rate' of 1 ½ % per month – 18% per annum and is added to all balances owed 60+ days. Any balance past due 90 days or more will be submitted to an attorney and/or agency for legal collection for which the undersigned agrees to be 100% responsible for all monthly service charges, costs related to but not limited to all collection related expenses, attorney fees, court & filing fees. Returned checks, debit & credit charges made payable to this facility for insufficient funds, stop payments or other reasons of non-payment will be assessed a $50.00 charge.

I acknowledge that I have read or have had read to me and understand all terms and conditions of this accident and injury assignment - authorization of lien as stated on this form and agree to all terms and conditions. A photocopy of this document shall be considered as effective and valid as the original.

_____

Print Name of Patient

_____ _____

Signature (if minor, parent must sign) **Date**