Stanlick
my Bills

Irrevocable Assignment Lien, and Authorization
Insurance Benefits and Attorney

Patient: ___________________________ Insured:___________________________

Claim #: __________________________ Policy #: __________________________

Date of Loss: _____________________ Adjuster:_________________________
(____)_______________

To whom it may concern:

I hereby authorize and direct you, my insurance company, liability insurance adjuster, and/or my attorney to pay directly to: **Stanlick Chiropractic (Office)** such as may be due and owing to this Office for services rendered to me, both by reason of accident or illness, or any other amounts that are due this office, including but not limited to: interest charges or finance fees and/or collection fees. I authorize and direct you to withhold such sums from any disability benefits, medical payments benefits, no fault benefits, health and accident benefits, workman's compensation benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgement or verdict on my behalf as may be necessary to protect said Office. I hereby further give a lien to said Office against any and all insurance benefits named herein and any and all proceeds of any settlement, judgement or verdict which may b paid to me as a result of the injuries or illness for which I have been treated by said Office. This is to act as an assignment of my rights and benefits to the extent of the Office's services provided and any additional fees or charges that may have accrued. This includes but is not limited to, interest fees and collection fees, including reasonable attorney's fees which may be payable as the result of my account being past due.

In the event any insurance company obligated to make payments to me upon charges made by this Office for their services refuses to make such payments, upon demand by me or this Office, I hereby assign and transfer to this Office any and all causes of action that I might have or that might exist in my favor against such company and authorize this Office to prosecute said cause of action either in my name or in the Office's name and further I authorize this office to compromise, settle, or otherwise resolve said claim or cause of action as they see fit.

I understand and agree that I remain personally responsible for the total amounts due the Office for their services, and any additional fees, including but not limited to interest and collection fees should my account become past due. I further understand that this Assignment Lien and Authorization does not constitute any consideration for the Office to await payments and they may demand payments from me immediately upon rendering services at their option. I understand that 1.5% interest per month may be added to any amounts due this Office which are more than thirty days past due, and that said interest charges are protected by this Assignment, Lien and Authorization as are the fees for services provided. I further understand that payment due this Office is not contingent upon any settlement, judgement or verdict by which I may recover said fee. I agree to pay all costs of collection of any balance due this Office, including reasonable attorney's fees.

I authorize this Office to release any information pertinent to my case to any insurance company, adjuster, or attorney or doctor to facilitate collection under this Assignment, Lien and Authorization I agree that the above mentioned Office be given Power of Attorney to endorse/sign my name on any and all checks for payment of amounts due this Office. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him/her. A photocopy of the Assignment, Lien and Authorization shall be considered as effective and valid as the original. I agree not to rescind or revoke any of the terms of this Assignment, Lien and Authorization, and this document shall be valid from the date I signed it until all amounts due the Office are paid in full.

Signed:____________________________ Date:________________________
Patient or Responsible Party if Minor

Witness:_______________________________

The undersigned, being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgement, or verdict as may be necessary to adequately protect said Office named above.

Signed: ____________________________ Date:_________________________

Printed Name:_______________________ Address:______________________

Attorney: Please sign this form, print or type name & address, and return it to:
241 W Northfield Blvd, Murfreesboro TN 37129 Ph:615-907-7400 Fax:615-907-7435