Townsend Chiropractic and Wellness Center
ASSIGNMENT – AUTHORIZATION & LIEN

I hereby irrevocably authorize & direct my insurance company, my attorney and any & all third party payor to pay directly to Dr. Rick Townsend all sums of money due them for any & all services rendered to me or minor by whom I am responsible for by reason of accident, illness and by any and all reason of any other bills that are due or may become due, and to withhold such sums from any disability benefits, including but not limited to foundation grants, governmental or agency benefits, medical payment benefits, no fault benefits, health and accident benefits, workers compensation benefits, and or any other insurance or third party benefits obligated to reimburse the undersigned or from any settlement, judgement or verdict on my behalf as may be necessary to adequately provide for any financial obligation owed this office and assignee.

The parties further agree that, in the event, my insurance company and/or attorney obligated to make payment to me upon the charges made by this office & assignee any and all causes of action that I might have or that might exist in my favor against such company and authorize this office & assignee to prosecute said cause of action either in my name or in the assignee's name and further I authorize this office assignee to comprise, settle or otherwise resolve said claim or cause or cause of action as they see fit. I understand that this does not relieve me of my personal responsibilities for all such charges in the even there is no recovery or if the recovery is insufficient to satisfy such charges. I hereby further agree to give a full lien to said office against any & all insurance benefits named herein any and all proceeds of any settlement, judgement or verdict which may be paid to the undersigned as a result of the injuries or illness for which I have been treated by said office & assignee. The undersigned patient and/or assignee further agree that the assignee's right for payment from the undersigned patient shall be tolled by any statute of limitations until a reasonable time has lapsed after either negotiations or litigation between third parties and the undersigned patient are resolved. A photocopy of this assignment shall be considered as effective and valid as the original. I voluntarily waive the statute of limitations regarding my doctors and/or this offices right to recover & agree to be held fully responsible for all debts I incur by this office.

It is further agreed that the undersigned patient shall remain personally responsible for the total amount due this office & assignee for its services. The undersigned further understand & agree that this Assignment, Authorization & Lien does not constitute any consideration for the office to wait for payment(s) and that they may demand full payment from me immediately and at anytime upon rendering service at their option. Such option requires that I pay for all sums due & owing in full within 10 days of demand. I further understand that a monthly service charge is computed by a 'periodic rate' of 1.5% per month which is an annual percentage rate of 18% which is applied to the previous balance after deducting current payments and that the service charge may change without notice. It is understood that returned checks made payable to this office for insufficient funds, stop payments or other reasons of non-payment will be assessed a $25.00 service charge for which I agree to be held responsible for. I understand that all money due this office will be paid in a timely manner with no amount of money due past 90 days from date service was incurred and that I am responsible for payment of all outstanding balances at that time, regardless of any attorney liens, representation of any attorney, pending settlement(s) or other matters unless approved in writing by this office in advance to the 90 day limit. Parties further agree & understand that if need arises accounts delinquent by 90 days may be placed to a legal collection agency for which I am fully responsible for and in full all court costs, filing fees, attorney costs & all associated collection costs.

I further understand and agree that as necessary this office and its staff may submit, prepare or complete medical records, consultations, depositions and/or court appearances on my behalf which I understand must be paid in full in advance and are not considered part of my account. I authorize this office to release any information pertinent to my case to any insurance company, adjuster, attorney or legal service bureau to facilitate collections under the terms of this document. I agree that the above mentioned office is given full power of attorney to endorse and/or sign my name on any & all checks for payment of any indebtedness owed this office & assignee.

I understand that this office, its doctors & staff are accepting my case based on examination findings & believe the outlined treatment should produce change and/or improvement. However as with any doctors treatment a guarantee of improvement or complete recovery cannot be made and it is even possible that no change will occur, but that I am still fully obligated to all charges for all services rendered to me.

SIGNATURE_________________________________ DATE_______________________