MARK PIERCE
CHIROPRACTIC CLINIC

ASSIGNMENT OF INSURANCE BENEFITS AND DIRECTION TO PAY

I, ____________________________________, hereby instruct and direct any insurance carrier that is providing insurance benefits on my behalf under any policy of insurance to make out a check to, and directly pay, MARK PIERCE CHIROPRACTIC CLINIC for professional medical and rehabilitative services rendered to me. This includes a direct assignment of my rights and benefits under any policy of insurance and may only be revoked with the express written consent of MARK PIERCE CHIROPRACTIC CLINIC. This assignment of insurance benefits pertains to any and all professional services, including past services, provided by MARK PIERCE CHIROPRACTIC CLINIC in relation to my health insurance and/or motor vehicle accident of .

This assignment of insurance benefits is provided so that MARK PIERCE CHIROPRACTIC CLINIC may attempt to collect any unpaid or overdue insurance benefits from the insurance carrier. This includes the assignment of any cause of action that might accrue against such insurance carrier for its failure to pay insurance proceeds. Such assignment is given in consideration of professional medical and rehabilitative services.

I authorize any holder of insurance information about me to release such information to MARK PIERCE CHIROPRACTIC Clinic needed to determine the insurance benefits or to assist in the collection of payment for services. I authorize MARK PIERCE CHIROPRACTIC CLINIC to contact the insurance company for an exact dollar amount of insurance benefits that are available under any policy of insurance that affords coverage, and to obtain any payout or check ledger reflecting insurance benefits that have been paid out on my behalf.

I understand that there may be services provided that may not be paid under the benefits of my insurance plan and therefore I am responsible to pay for these services outside of my Co-Pay amounts.

A copy of this agreement will be as valid as the original

I have read and I do understand this assignment thoroughly.

Patient's Signature ______________________________

Signature of Legal Guardian ______________________________________ Date ________________
(when patient is a minor child)

X-RAY CONSENT FORM

I, ________________________________, hereby release MARK PIERCE CHIROPRACTIC CLINIC of liability from complications that may arise from receiving any x-ray studies. I understand the inherent risk associated with exposure to x-rays. I understand the need for x-rays to properly diagnose and treat my condition.

ATTENTION FEMALE PATIENTS: I, ____________________________, hereby certify to the best of my knowledge that I am not pregnant and release MARK PIERCE CHIROPRACTIC CLINIC of liability for any complication that may arise from receiving any x-ray studies. I understand the inherent risk associated with exposure to x-rays. I understand the need for x-rays to properly diagnose and treat my condition.

ATTENTION PARENTS: Please complete Parent Consent Form for minor children.

I, ______________________________, being parent or legal guardian of ________________________________, hereby consent to the treatment and performance of diagnostic testing of this minor at MARK PIERCE CHIROPRACTIC CLINIC by Dr. Mark A. Pierce or any legal agent of this clinic.

Patient Signature ___________________________________ Date ________________

Parent Signature ____________________________________ Date ________________

Witness ____ Date ________________