ROBERTS CHIROPRACTIC CENTER
2497 SOUTH ROANE STREET, SUITE 260
HARRIMAN, TN 37748

SPECIFIC AND IRREVOCABLE AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to treat me, I agree to the following:

1) You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred for services rendered to me by you or any member of your staff acting on your behalf.
2) I authorize the direct payment to you of any sum I now or will owe you by my attorney out of proceeds of my settlement of my case or any insurance company obligated to reimburse me for the charges for your services or otherwise obligated to make payment to me or you based in whole or in part upon the charges made for your services.
3) In the event any insurance obligated by contractual agreement to make payment to me or to you for charges made for services and refuse to make such payment upon demand by you. I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name or names which is believed to be correctly set forth under pertinent data below) and authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until all reasonable efforts have the sum due from been made to collect the sums due from the insurance company or companies contractually obligated. You will refrain from attempts to collect the amounts owed directly from insurance proceeds (whether it be all or part of what is due) I personally owe you.

I UNDERSTAND THAT MY INSURANCE OR HEALTH CARE PLAN MAY NOT PROVIDE COVERAGE FOR SUCH ITEMS AS DEDUCTIBLE, CO-PAYMENTS, NON-COVERED CHARGES, OR CHARGES WHICH EXCEED INSURANCE COMPANY FEE LIMITS OR ALLOWANCES.

IN THE EVENT MY INSURANCE OR HEALTH CARE PLAN DOES NOT PROVIDE COVERAGE FOR THE ABOVE ITEMS, I UNDERSTAND THAT I WILL REMAIN FINANCIALLY RESPONSIBLE. I ALSO UNDERSTAND THE DOCTOR WILL ACCEPT, AS PAYMENT FOR SERVICES RENDERED THE PROCEEDS OF APPLICABLE INSURANCE OR OTHER CARE PLAN BENEFITS.

SIGNED____ DATE__________________