MATOSHKO
Chiropractic Clinic, LLC

5754 15 Mile Road, Sterling Heights, MI 48310
586-795-8989 . Fax: 586-999-5989 . matoshkochiropractic.com

I understand and agree that health and accident policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that this Chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this Chiropractic office will be credited to my account by receipt. However, I clearly understand and agree to all services rendered to me are charged directly to me and I am personally responsible for payment. I understand that if I suspend or terminate my care, any fees for professional services rendered to me will be immediately due and payable.

AUTHORIZATION AND PAYMENT

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.

2. I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case and by any insurance company obligated to make payment to me or yo based in whole or in part upon the charges made for your services. If my current policy prohibits direct payment to Dr. Matoshko, then I hereby instruct any insurance company to make the check out to me as patient and mail it to me as follows: C/O Matoshko Chiropractic Clinic, 5754 15 Mile Road, Sterling Heights, MI 48310

3. In the event of any insurance company that is obligated by contractual agreement to make payment to me or to you for the charges made for your services, refuses to make such payments upon demanding by you, I hereby assign and transfer to you the cause of action that exists in my favor against any favor against any such company and authorize you to prosecute said action either in my name as you see fit. I also further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. I authorize Dr. Matoshko to complain to the insurance commissioner on said patient's behalf for any reason. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company, or companies, contractually obligated, you will refrain from attempts and efforts to collect amounts owed directly from me. I understand that whatever amounts you do not collect from the insurance company's/companies' proceeds, whether it be all or part of what is due, I personally owe you.

4. This authorization and assignment shall be valid and effective for all charges and fees hereafter, incurred, retracted and revoked by me in writing.

DATE: _____

SIGNED: _____

WITNESS: _____