C. C. Chiropractic, Inc.
at University HTS

2260 Warrensville Center Road, #208
University Heights, OH 44118
216-759-0616

AUTHORIZATION AND ASSIGNMENT

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

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 by you or any member of your staff acting on your behalf.

I fully understand that my insurance policy is a contract between my insurance company and myself. C. C. Chiropractic, Inc. is not a party to that contract. **As a cash patient, the balance is due in full each visit.**

I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds or any settlement of my case, and/or any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services. Any insurance checks, paid directly to me, will be endorsed or a personal check sent for the said amount and immediately sent to C. C. Chiropractic, Inc. for payment of services rendered. Any insurance check withheld from C. C. Chiropractic, Inc. can be considered table income and information can be sent to the IRS.

I realize if I am the parent or guardian accompanying a minor child, I am responsible for full payment for services rendered.

I understand whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due) I personally owe you. I hereby promise to pay my bill in full within ten (10) days from the date my liability claim is settled or after the passage of two (2) months from the date of my last treatment, whichever comes first.

I also understand that all unpaid balances shall be subject to an interest rate of 1 ½% per month. Finally, any delinquent accounts may be sent to collections at the patient's expense, as well as any other interest or collection fees.

_____ _____

Patient Signature Date