

# JOHNSON CHIROPRACTIC

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## ASSIGNMENT OF BENEFITS

FOR GOOD AND VALUABLE CONSIDERATION RECEIVED, THE RECEIPT AND SUFFICIENCY OF WHICH IS HEREBY ACKNOWLEDGED, I hereby assign and convey to George Gary Johnson, D.C., which offices at Johnson Chiropractic, 2515 Gus Thomasson Rd., Suite A, Mesquite, Texas 75150 (hereinafter referred to as "Doctor") to the extent of my bill for health care services with Doctor, any and all claims which I may have:

- a) For benefits provided under any policy of insurance or other health care plan, including but not limited to the following described policies:

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- b) Against any other party who may be legally responsible for my health care costs.

Pursuant to this instrument of Assignment, I hereby direct payment be made directly to Doctor.

I understand and agree that payment for services rendered by Doctor is due upon receipt of the services but that Doctor has agreed to accept this Assignment as an accommodation to me and that Doctor, in his sole discretion, may revoke this Assignment at any time.

In the event that I receive directly any check, draft, or other benefits subject to this assignment at a time when there is still a balance due Doctor, I agree to deliver such check, draft, or benefits to Doctor, immediately upon receipt, and the proceeds thereof shall be applied to my bill.

Doctor is empowered and is hereby assigned the right to request and receive from any insurance company or health care plan any and all information and documents pertaining to my policies including a copy of such policy, and any information or supporting documentation concerning or touching upon the handling, calculation, processing or payment of any claim.

This Assignment Of Benefits will be valid for two years following the assigned date.

In the event that any provision of this agreement is determined to be invalid or unenforceable, all other provisions of this agreement shall remain enforceable.

IN WITNESS WHEREOF, this Agreement has been entered the day and year set forth below.

\_\_\_\_\_  
Patient Name Printed

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date