Optimal Health Chiropractic LLC
1507 Park Center Dr. Suite 1A
Orlando Florida 32835

ASSIGNMENT OF INSURANCE BENEFITS, POWER OF ATTORNEY AND
RELEASE OF INFORMATION

The undersigned patient/insured _____(print name of patient/insured or parent/guardian if patient is a minor), knowingly, voluntarily and intentionally assigns the benefits of insurance and any over due interest payments under the No-Fault Policy of Automobile Insurance, also known as Personal Injury Protection(PIP), or Medical Payments policy of insurance from my automobile insurer or the responsible insurer to the above described medical provider for any and all services rendered to the undersigned patient/insured. It is the intent of the medical provider to accept this assignment of benefits. The undersigned patient/insured directs the insurer to pay the medical provider directly (i.e. payments to be mailed and made payable to the medical provider only and not to me) for the services rendered. The insurer is further directed by the provider and the patient to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured from liability unless there has been a prior written settlement agreed to by the medical provider and the insurer as to the amount payable under the insurance policy or contract. The provider hereby objects to any reductions or partial payments made at the discretion of the insurer. Any partial or reduced payment issued and deposited by the provider shall be done so under protest and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted. In the event the subject medical benefits are disputed for any reason, including but not limited to, medical reasonableness and/or necessity, the undersigned patient/insured hereby instructs the insurer to set aside any amount disputed (i.e. to escrow the money) and not pay the disputed amount to anyone, including myself, or any entity until the dispute is resolved. Any partial payment, regardless of the accompanying language, will be deemed a partial payment and the insurer will be making the payment at its own risk unless there is a prior written settlement agreed to by this provider. I hereby instruct the insurer to notify the above immediately of any dispute.

The undersigned patient/insured agrees to pay any deductible, co-payments, for services rendered after the policy insurance exhausts, and for any other services unrelated to the automobile accident. In the event the medical provider is required to file a lawsuit against the insurer for payment, the undersigned patient/insured agrees to cooperate with the medical z provider's attorney and the insurer. I understand this assignment will remain in full force and effect and will **NOT** be revoked unless the revocation is agreed to by both the medical provider **AND** the undersigned patient or the patient's attorney. This assignment applies to both past and future medical expenditures. A photocopy of this assignment is to be considered as valid as an original.

Power of Attorney I also agree the above provider is hereby given the power of attorney to sign my name on any checks for payment for services provided by the above provider.

Release of Information I hereby authorize this medical provider or their representative to furnish my insurance company or companies and my attorney with any and all information that may be contained in my medical records, to request a copy of my PIP and/or Med-Pay payout sheet from the insurer and obtain any insurance coverage information in my file. I also hereby authorize this medical provider to obtain copies of my medical records, including but not limited to, documents, reports, scans, notes, opinions, x-rays, and MRI'S, from any other medical provider or any insurance company.

Caution! Please read before signing. If you do not completely understand this document please ask us to explain it to you . If you sign below will assume you understand and agree to the terms.

Patient's Signature:_____ Date:_____
(If patient is a minor/signature of parent/guardian)

Medical Provider's Signature:_____ Date:_____

**Any person who knowingly and with intent to injure, defraud or deceive any insurer, filed a statement of claim containing any false, incomplete, or misleading information may be guilty of a felony of the third degree.