

**ANTHON
CHIROPRACTIC
CARE**



DR. GEORGE ANTHON, JR.
105 SOUTH CHERRY
HAMMOND, LA 70403
504-542-1600

AUTHORIZATION AND ASSIGNMENT

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

1. I, the undersigned, a patient in the clinic hereby authorize Anthon Chiropractic Care (whomever may be designated as assistants) to administer such treatment as are necessary.
2. You are authorized to release any information you deem appropriate concerning physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you.
3. I authorize to you direct payment to you any sum I now or hereafter owe you by my attorney out of proceeds of any settlement of my case and/or by any insurance company obligated to reimburse me for the charges for your services or otherwise obligated to make payments to me or you based in whole or in part upon the charges made for your services.
4. In the event any insurance company is obligated by contractual agreement to make payment to me or to you for the demand by you I hereby assign and transfer to you the cause of action that exists in my favor against any such company and authorize you to prosecute said either in my name or your name as you see fit and further as you see fit, I understand that whatever amount you do not collect from insurance proceeds, Whether it be all or part of what is due), I personally owe you.
5. A photocopy of this assignment shall be valid and have the same effect as the original.
6. Should it be necessary to place my account in the hands of an attorney or collection agency for collection, I agree to pay reasonable attorney's fees, court cost and/or collection fees.

SIGNATURE _____ DATE _____

INSURANCE CO. _____

NAMED OF INSURED _____

POLICY # _____ GROUP# _____

PATIENTS NAME _____