

AUTHORIZATION AND ASSIGNMENT FOR DIRECT PAYMENT

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

1. You are authorized to release any information you deem appropriate concerning my health 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/or by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collecting the amounts owed, directly from me. I understand that whatever amounts you do not collect from insurance companies proceeds, whether it be all or part of what is due, I personally owe and agree to pay to you.
4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this State of _____.
5. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.
6. This Authorization for Assignment will be in continual effect until revoked by both parties.

Date

Patient / Insured Signature

RECORDS RELEASE

To _____, I hereby authorize you to release to Dr. _____ any information including the diagnosis and records of treatment or examination rendered to me for all care during the period from _____ to _____.

Date

Patient / Insured Signature

Date

Staff Signature

RELEASE FROM CARE

I, _____ hereby understand that Dr. _____ is releasing me from care, for my _____ accident that occurred on _____, and that I have reached a pre-accident status or a maximum medical improvement. I further understand that all expenses incurred from this accident are my responsibility or the insurance company's and that any healthcare expenses incurred at _____ office after the date below will be my personal responsibility. I will make financial arrangements for payment directly.

Patient Signature

Date

Staff Signature